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ABSTRACT

A collection of 12 lessons, this volume covers a wide range of concerns in mental health counseling. The lessons, which may be applied toward continuing education credits, are: (1) "Perspectives on the Essentials of Clinical Supervision" (Stephen A. Anderson); (2) "Adlerian Group Psychotherapy: A Brief Therapy Approach" (Manford A. Sonstegard, James Robert Bitter, Pari Peggy Pelonis-Peneros, and William G. Nicholl); (3) "Substance Abuse Treatment for Pregnant and Parenting Women" (Rivka Greenberg, Judith Fry McComish, and Jennifer Kent-Bryant); (4) "Family Therapy for with Lesbians and Gay Men" (Maeve Malley and Fiona Tasker); (5) "Psychological and Cognitive Correlates of Coping by Patients with Multiple Sclerosis" (William W. Beatty and Brian T. Maynard); (6) "Eye Movement Desensitization and Reprocessing (EMDR): Clinical Implications of an Integrated Psychotherapy Treatment" (Francine Shapiro and Louise Maxfield); (7) "Counseling Strategies with Women Survivors of Child Sexual Abuse" (Kathleen M. Palm and Victoria M. Follete); (8) "Identifying and Treating Body Dysmorphic Disorder" (Dean McKay); (9) "Masochistic Phenomena Reconceptualized as a Response to Trauma: Recovery and Treatment" (Elizabeth Howell); (10) "Counseling Poor, Abused, and Neglected Children in Fair Society" (Brenda Geiger); (11) "Chronic Fatigue Syndrome: Assessing Symptoms and Activity Levels for Treatment" (Constance W. Van der Eb and Leonard A. Jason); (12) "The Limitations of the DSM-IV as a Diagnostic Tool" (G. J. Tucker); and (Special Report) Jealousy, Communication, and Attachment Style (Laura K. Guerrero). Each lesson contains references. (GCP)

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Directions in Mental Health Counseling

Volume 11

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Frederic Flach

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24.	○	○	○	○	48.	○	○	○	○

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Lessons 7–12 will be mailed to you in July

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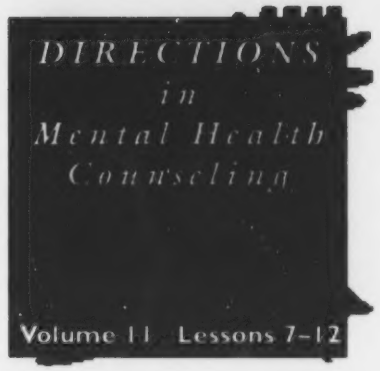

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Perspectives on the Essentials of Clinical Supervision

Stephen A. Anderson, PhD

Dr. Anderson is a Professor in the Marriage and Family Therapy Training Program, University of Connecticut, School of Family Studies, Storrs, CT.

Introduction

This lesson describes some of the recent developments that have occurred in the area of clinical supervision, particularly in the field of marriage and family therapy. Supervision has been defined as a continuous relationship between supervisor and supervisee that is focused on supervisees' practice settings and their development of competency as they gain practical experience (Liddle & Saba, 1982). It involves the following key elements: (a) an experienced therapist, (b) safeguarding the welfare of clients by (c) monitoring less experienced therapists' performance, (d) with real clients in clinical settings, and (e) with the intent to change the therapist's behavior to resemble that of an exemplary therapist (Mead, 1990). The supervisor's responsibility is even broader, and also includes the supervisee's professional development and socialization into the profession (Anderson, Rigazio-DiGilio, & Kunkler, 1995; Todd & Storm, 1997).

Supervision is distinguished from training, which is considered a broader more encompassing endeavor. *Training* involves the comprehensive teaching of theories, skills, and techniques through a variety of modalities that generally include classroom instruction, organized curriculum, and clinical supervision (Anderson, et al., 1995). Thus, supervision may occur independent of clinical training, but is generally an important element of training.

If one reviews the clinical supervision in family therapy, it is apparent that a key concept has been that of isomorphism. ***Isomorphism* suggests that interaction patterns, content (e.g., theoretical orientation, assumptions about client change, preferred treatment methods), and affect tend to be replicated at different levels of the therapeutic system** (Liddle, Bruenlin, Schwartz, & Constantine, 1984). Although the concept of isomorphism has a number of implications and applications in therapy and supervision (cf., Liddle, 1991), one important aspect is the simple notion that supervisors will tend to advise their supervisees in the method and model of therapy that they themselves practice.

In some respects, this makes intuitive and practical sense. A supervisor is likely to understand the supervisee's clinical cases from his or her own theoretical framework and to recommend to the supervisee the very same clinical interventions that he or she has found to be successful in their own clinical work. For instance, a behavioral supervisor might focus on the antecedents and consequences that surround the target behavior and recommend interventions that could be directed at those behaviors (e.g., reinforcement schedules, contingency contracts). In contrast, a structural family therapy supervisor would assess the functioning of the family's subsystems and interpersonal boundaries, and direct interventions at the immediate interactions between family members during the therapy session.

Much of the supervision literature has been influenced by this notion that supervisors tend to replicate their own assumptions and beliefs about therapy with their supervisees. Generally, this literature has emphasized two primary dimensions thought to be essential to successful supervision: technical skills and personal growth. There is no doubt that this perspective has produced a wealth of useful conceptual and technical knowledge that has informed the supervision enterprise. However, the danger in this view is that it is based almost exclusively on theories and data produced by supervisors and trainers in the field. Other voices or perspectives have been less influential in designing the process and content of effective clinical supervision.

In the following sections, we will examine some of the contributions from supervisors and trainers and also examine what has been omitted. In particular, two additional sources of information will be discussed: (1), the views of supervisees, and (2) research on the effectiveness of psychotherapy. The goal is to highlight the value of supervisors taking the perspective of other key contributors to the supervisory and therapeutic system into account — in particular, the perspectives of supervisees and clients.

Predominant Literature on Supervision: Technical Skills and Personal Growth

Technical Therapeutic Skills:

Numerous authors have discussed the importance of supervisees developing therapeutic skills (Anderson et al., 1995; Liddle, 1991; Todd & Storm, 1997). Four basic categories of skills are often assumed to be essential.

Perceptual Skills

These skills are necessary to see and describe accurately the behavioral data of the therapy session. Perceptual skills allow the supervisee to distinguish the key elements of the clients' presenting issues from the wealth of data that is presented in the course of a typical therapy session.

Conceptual Skills

These skills are necessary to translate clinical observations into meaningful language; this generally involves the application of one or more theories. An important part of conceptualizing observed dysfunction is the ability to generate treatment goals on the basis of these formulations.

Intervention Skills

These skills are the in-session behaviors that allow supervisees to help modify clients' problematic behaviors and interactional patterns (Anderson, 1992; Cleghorn & Levin, 1973). The specific content that is taught in regard to perceptual and conceptual skill categories is highly dependent upon the model of therapy practiced by the supervisor since each model has its own theoretical assumptions and intervention strategies. However, consensus has emerged, strengthened by empirical studies, that certain behaviors, which do not vary with theoretical outlook, contribute to successful therapy. **These behaviors, which contribute significantly to family therapy, include maintaining an active rather than a reflective or passive role, stimulating interactions among family members, asking questions, clarifying verbal communications, maintaining a clear focus for the session, and negotiating a clearly defined therapeutic contract with clients** (c.f., Anderson, Atilano, Bergen, Russell, & Jurich, 1985; Barton & Alexander, 1977; Bergin & Garfield, 1994; Laszloffy, 2000).

Relationship Skills

These skills are necessary for engendering trust and

exuding empathy, warmth, genuineness, and optimism. These skills have been found to be essential in establishing an effective therapeutic alliance with clients (Anderson, 1992; Lebow & Gurman, 1995).

The development of basic skills appears to help supervisees feel less anxious, more confident, and better prepared for seeing clients in treatment (Figley & Nelson, 1989; Street & Treacher, 1980; Wetchler & Fischer, 1992). The development of therapeutic skills is generally accomplished through the use of modalities such as case discussion, live supervision, videotape review of sessions, and simulated role plays of clinical situations (Sprenkle & Wilkie, 1996; Todd & Storm, 1997; Watkins, 1997).

Personal Growth:

Not all supervisors have agreed that personal growth is an important aspect of supervision (c.f., Haley, 1988; Minuchin, 1974; Nelson & Johnson, 1999). In fact, the value of skills training versus personal growth has been debated in the literature over the years (c.f., Anderson et al., 1995; Liddle, 1991). **Those who emphasize the personal growth dimension in supervision focus on the supervisee's resolution of personal conflicts that might affect how they understand and relate to their clients** (Aponte, 1992, 1994; Deacon, 1996; Roberto, 1997). Insight, self awareness, and examination of one's personal experiences as they affect clinical work are emphasized.

Because the therapeutic relationship is thought to be the primary vehicle for change, any emotional overreactions, under-reactions, or blind spots that might endanger it must be examined and understood. Whitaker referred to such counter-transference reactions as "slivers of pathology." When the therapist remains open to experiencing and processing these reactions, it encourages clients to do the same, and in so doing keeps the therapeutic system open, alive, and fluid (Neill & Kniskern, 1982). Examining the supervisee's family of origin experiences or obtaining a referral for personal therapy are generally encouraged (Binder & Strupp, 1997; Roberto, 1997). The assumption here is that the supervisee's emotional reactions in therapy derive at least in part from their earlier formative experiences with parents and significant others. **Understanding the connections between these past and present emotional responses are thought to enhance therapeutic effectiveness.**

Case Example:

A young, female supervisee reported in supervision that she was having difficulty dealing with a divorced mother of two adolescent daughters. The mother was described as "domineering," "opinionated," and "difficult to reach." In a recent family session, the mother had become angry at the therapist and complained that the therapist did not appreciate her views on how to raise her children. Furthermore, the mother was upset that the therapist did not support her in her wish to change from family sessions to having each of the girls seen separately in individual therapy. The supervisee acknowledged that she often sided with the daughters in sessions and indicated an openness to examining this in the supervision. However, on the other point, she remained convinced that it was in the girls' best interest to have regular sessions with their mother.

An examination of the supervisee's own family of origin experiences revealed that her own mother had alternated between periods of being supportive and nurturing and periods of becoming angry, harsh, and punitive for no apparent reason. During these later times she would try to avoid her mother, or do whatever was needed to appease her mother in order to calm her down. The therapy had evoked a similar response.

The supervisee had primarily identified with the daughters, viewing them as oppressed by their tyrannical mother. This position had alienated the mother and elicited her anger; the supervisee responded by becoming passive and placating. From this position she was not able to press for continued family sessions so that the conflicts in the mother–daughter relationships could be resolved. Once the parallels between her own experiences and the client family had been processed in supervision, she was able to separate her personal reactions from that of the family members', empathize with both the daughters and mother, and press more assertively for joint sessions to work on repairing their relationships.

Supervisees' Views on Supervision

As noted earlier, much of the available literature on

supervision has been written from the perspective of supervisors and trainers. However, studies have begun to emerge which asked the supervisees what constitutes a positive supervision experience. Four key dimensions appear to be important to supervisees.

The first two, ***attending to personal growth***, and, ***receiving conceptual and technical guidance*** are consistent with the above views of supervisors and educators (Hines, 1996; Hutt, Scott & King, 1983; Ladany, Hill, Corbett, & Nutt, 1996; Sumerel & Borders, 1996; Worthen & McNeill, 1996).

Open Learning Environment:

The third dimension involves experiencing an open supervisory environment. **This dimension emphasizes the supervisor's willingness to foster a learning environment where mistakes are viewed as a likely and important part of the learning process** (Ladany, Hill, Corbett, & Nutt, 1996), **and where supervisees are encouraged to explore and experiment** (Allen, Szollos, & Williams, 1986; Anderson, Schlossberg, & Rigazio-DiGilio, 2000; Hines, 1996; Worthen & McNeil, 1996). **This type of environment additionally promotes reciprocal feedback wherein supervisors regularly provide feedback to supervisees regarding their strengths, limitations, and progress, and supervisees are allowed to provide feedback to the supervisor.**

Supervisors are seen as self-disclosing, and as providing opportunities for supervisees to see one another's work. By encouraging supervisees to show their clinical work to others and risk displaying their imperfections, avenues for valuable feedback from peers, as well as supervisors, are provided. **Also, this sharing of work strengthens the open environment and conveys the idea that each individual can learn from those around them**. Typical methods for incorporating this dimension into supervision include seeing supervisees in group supervision where videotaped sessions are reviewed, offering supervisees opportunities to observe one another's work from behind one-way mirrors, and having supervisees work as co-therapy pairs or in therapy teams. Teams allow the supervisee conducting the session to receive immediate guidance and support from other supervisees and supervisors who observe from behind the one-way mirror. Finally, **this environment promotes an acceptance of differences of opinions, values, life experiences, and theoretical orientations** (Anderson, Rigazio-DiGilio, Schlossberg, & Meredith, 1998, Anderson, et al., 2000).

However, it is important that an environment of openness be counterbalanced with a clear and definable structure for the supervision experience. **It is important for supervisees to be clear about their supervisor's expectations and that the goals and tasks of the supervision be mutually agreed upon** (Ladany & Friedlander, 1995).

Communication and Encouragement Between Supervisor and Supervisee:

The fourth dimension is related to supervisees receiving respect, support, and encouragement. **Supervisees found it essential that their supervisors convey the message that they are important and valued; this is accomplished, in part, by the supervisor regularly providing praise and encouragement.** Worthen and McNeil (1996) referred to this as the supervisor, "conveying an attitude that manifested empathy, a nonjudgmental stance toward the supervisee, and a sense of validation and affirmation" (p. 29).

This dimension also represents the degree to which supervisors arranged a regular schedule for supervisory sessions and then adhered to it. **Maintaining a regular schedule of supervisory sessions demonstrates a respect for the personal time demands of the supervisee and communicates that the supervisor values the supervisee as a colleague.** Respect, support, and encouragement also are perceived to be conveyed by the supervisor who is accessible outside of regularly scheduled sessions, should the need arise, and by the supervisor not allowing frequent interruptions during supervision sessions (e.g., telephone calls or interruptions for administrative matters; Anderson et al., 1998; 2000).

These later two dimensions, derived from supervisee's own experiences, can be thought of as providing the proper context for the learning of technical skills and personal growth. That is, an environment where it is safe to experiment and learn from one's mistakes, coupled with the supervisor's attitude of respect and encouragement, are likely to maximize the potential for

learning specific clinical skills and the use of one's self as a therapeutic resource.

Psychotherapy Outcome Research

Over four decades of psychotherapy, outcome research has been unable to identify one particular model of therapy that is superior to others (Bergin & Garfield, 1994). This has led many to conclude that "common factors" must exist in all or most therapies. It is thought that these factors explain a substantial amount of the well-documented improvements found in psychotherapy clients, and also explain why no differences between treatments have been found (Lambert & Bergin, 1994).

Although there have been a number of formulations that attempt to identify the common factors at work in psychotherapy, one of the most promising is the work of Lambert (1992) and Miller and colleagues (1997). On the basis of extensive reviews of the psychotherapy outcome literature, they proposed the following four common factors that explain successful therapy.

Extratherapeutic Factors:

Thought to account for 40% of variance in therapy outcome, this factor involves elements that occur outside of the therapy experience. These are characteristics of the client and their current circumstances, and involve "the total matrix of who [the clients] are–their strengths and resources, the duration of their complaints, their social supports, the circumstances in which they live, and the fortuitous events that weave in and out of their lives" (Miller, Duncan, & Hubble, 1997; p. 26). **These factors refer to any and all aspects of the client and his or her environment that facilitate recovery, regardless of formal participation in therapy** (Lambert, 1992). This might be a promotion at work that instills greater confidence, a sudden loss of a dear friend that causes one to reevaluate one's life, or the realization that one's family or friends will stand by one in a time of need. The important point is that this factor refers to events or processes that occur outside the context of treatment, but that might nonetheless exert a powerful influence over the outcome of therapy. **Thus, it becomes important for the therapist to consider not only what clients need, but what they already possess in their world that can be put to use in helping them reach their therapeutic objectives** (Miller et al., 1997).

Therapeutic Relationship:

Researchers estimate that **as much as 30% of the variance in psychotherapy outcome is due to relationship factors**, making this the second-most important element of successful therapy. **Clients who are motivated, engaged, and actively participate in the work of therapy benefit most from the experience, and the quality of the client's participation in treatment is strongly related to the bond or alliance they form with the therapist.** Strong alliances are formed when the client perceives the therapist to be warm, trustworthy, nonjudgmental, and empathic (Lambert & Bergin, 1994). Furthermore, a strong therapeutic alliance is based upon collaboration. The therapist works with the client, rather than doing things to the client, to achieve the desired outcome.

Expectancy, Hope, and Placebo:

Research has shown that simply expecting therapy to be helpful can overcome demoralization and assist in client improvement (Frank & Frank, 1991). In his widely cited review of therapy outcome literature, Lambert (1992) estimates that 15% of the variance in therapy outcome is accounted for by this factor. **The creation of hope is strongly influenced by the therapist's attitude toward the client during the opening moments of therapy.** Pessimistic attitudes that emphasize pathology or the difficult, long-term, and painful nature of change are likely to minimize this potentially curative factor. On the other hand, **an emphasis on new possibilities, and a belief that therapy will work, can instill hope and a positive expectation for improvement** (Miller et al., 1997). Confidence that therapy can work must be genuine, not a superficial effort to "cheer the client up." It must take into account the validity of the client's current struggles and the possibility for change. In practice, it requires **paying less attention to what is wrong with clients and how to fix them, and paying more attention to what is possible for clients and helping them reach these goal** (Miller et al., 1997).

Therapeutic Technique:

Lambert (1992) estimates that the **therapist's model and preferred techniques account for the remaining 15% of the overall impact of therapy**. He noted that "patients don't appreciate these techniques and they don't regard these techniques as necessary. They hardly ever mention, ever, a specific technical intervention the therapist made. I'd encourage therapists to realize their phenomenological world about the experience of therapy is quite different than their patient's experience. The nontechnical aspects are the ones patients mention." Successful interventions on the part of the therapist fit with a client's experience and interpretation of their problems. They flow naturally from paying attention to what a client indicates is important to them and cannot be separated from the relationship in which they occur (Miller et al., 1997).

The implication of the psychotherapy outcome research for supervision and training is clear. Supervisees should be taught that clients have more to do with the successful outcome of therapy than do therapists. Client's personal strengths and life experiences outside of the therapy have a profound effect, as do the intangible expectations (e.g., hope, optimism) that clients bring to the therapy. This is not to say that the role of the therapist is not important. Rather, the therapist's contribution is to engage the client in an alliance.

An alliance is based on collaboration in which the goals and tasks to be completed in therapy are decided together. The therapist's role also includes confidently promoting the attitude that therapy can be successful. When specific therapeutic methods or interventions are introduced, they are most likely to be successful when they are congruent with clients' own strengths, resources, experiences, abilities, and world view. A crucial component is the therapist's attitude toward the client; viewing them as capable and possessing the strengths necessary to solve their own problems will help the client to do so. Therapy should enhance clients' feelings of personal control and help them recapture their belief in the possibility of change (Miller et al., 1997).

Each of the three perspectives reviewed above (supervisor's, supervisee's, and client's) offers some ideas about what constitutes successful supervision In the next section, the implications of these various perspectives will be discussed.

Implications for Supervisors

There is no question that supervision must assist the supervisee in achieving competence in implementing therapeutic skills and techniques. And, inevitably supervisors will continue to teach their charges what they themselves believe to be the critical conceptual and technical skills. That may be a pure model of psychotherapy or an integration of elements from various models. Surveys that have asked supervisees directly have found that they too value this emphasis on practical skills; it helps them feel less anxious and more competent in their work with clients. However, supervisors should consider what the psychotherapy outcome literature suggests in this regard. The conceptual formulations and interventions most likely to be successful are those that emerge from the therapy process and fit with clients' own notions about their problems, what changes they believe are necessary, and their views on how these changes might occur. That is, it is not the therapeutic model that should prevail, but rather the clients' experience of themselves, the therapist, and the therapy.

Despite the ongoing debate that has occurred among supervisors, particularly in the family therapy field, as to the importance of personal growth in becoming an effective therapist, supervisees appear to highly value this component of the learning process (Anderson et al., 2000). However, the important point to consider here is that this personal dimension of learning works best when the supervisor conveys an attitude of support, respect, and openness. This involves verbal messages that communicate to supervisees that they are valued, but it also includes behaviors by the supervisor that reinforce this message. Being available outside of regularly scheduled supervision sessions, giving supervisees undivided attention during supervisory sessions, minimizing session interruptions, and allowing reciprocal feedback all help to create the type of environment that facilitates growth and learning.

It would appear that the needs of supervisees are not so different from those of clients. Supervisees value a supportive therapeutic relationship that is empathic, genuine, trusting, warm, and nonjudgmen-

tal. They want to engage in a collaborative relationship in which their opinions, abilities, and strengths are acknowledged. Thus, the supervisor should strive to create a facilitative and open environment at all levels of the therapeutic system. This includes the therapist–client subsystem as well as the therapist–supervisor subsystem.

As important as a positive relationship is to therapy (and supervision), supervisors may wish to remember that factors outside of therapy, as indicated in the psychotherapy outcome literature, account for even more of the overall effectiveness of treatment. These findings require us to expand our vision of supervision beyond the traditional emphasis on technical skills training and personal growth.

For instance, if many of the changes that clients make occur outside of therapy, **we may need to encourage our supervisees to become more "change focused," meaning that the therapist makes a concerted effort to listen and validate change, whenever and wherever it might occur** (Miller et al., 1997). For instance, during the opening moments of a session the therapist might inquire about what, if any, changes the client has noticed since scheduling the first session. Or, the therapist might ask about whether any changes have occurred between the previous and the current session.

This brief example of a client with complaints of depression and poor social skills illustrates the point:

> ***Th**: Have you noticed anything different in your life since our last meeting?*
>
> ***Cl**: No not much. I have been enjoying going to work more lately.*
>
> ***Th**: What have you done differently to make work more enjoyable?*
>
> ***Cl**: Oh, I don't know. I've just been getting along better with my coworkers.*
>
> ***Th**: What did you do to make that happen?*
>
> ***Cl**: Well we just ate lunch together one day at the cafeteria. I usually eat alone, but they asked me to join them. I got to know them a little bit better. We just had a nice conversation. They even laughed at some of my jokes.*
>
> ***Th**: So, when you showed them a little bit more about yourself, they enjoyed what they saw.*

Another implication is to place greater emphasis on what is right with clients as opposed to what is wrong with them. **The mental health field has become highly wedded to the diagnosis of psychological problems and this practice is unlikely to change, given the current emphasis on medical treatments and the influence of managed care. However, if clients' personal strengths and resources are important curative factors, then supervisees must be constantly reminded to incorporate these into their therapy.** This does not mean that skills in the *Diagnositic and Statistical Manual of Mental Disorders,* fourth edition (DSM-IV) diagnosis and knowledge about recent biomedical treatments are not important, because clearly they are. Perhaps, Miller et al., (1997) made the point best when they noted:

> **The key is the attitude the therapist assumes with regard to client ability when conducting clinical work. This attitude involves treating clients as if they are capable and possess the strengths and resources necessary to solve their problems . . . Approaching clients in this manner not only helps to combat demoralization and instill hope, but makes it clear that the responsibility for cure is the client's business (p. 68).**

Finally, helping to create positive expectations involves helping clients to replace demoralization with hope. **Research has shown that clients come to therapy not because they have problems, but because they have no hope of solving them alone.** They look at their future as more of the same, as opposed to a future offering new possibilities.

One way to combat this inertia is for the therapist to firmly believe that his or her approach will be beneficial. This is often a difficult task, especially for beginning therapists who are not yet confident that they will actually be helpful. **The supervisor's task here is to remain alert to feelings of self-doubt on the part of**

the supervisee, and remain available to provide the support and encouragement the supervisee needs to achieve the level of confidence necessary to activate client's positive expectations. This might involve supervision modalities outside of the traditional one-to-one case discussion session such as live supervision, co-therapy with the supervisee, videotape review of sessions, or simulated roleplays of therapy sessions (Anderson et al., 2000).

Another way to combat this demoralization is to offer clients a different vision of the future. Although all therapeutic change must take place in the present, past events, or interpretations of these events, can place restraints on the range of possibilities clients entertain about the future (Anderson & Boylin, 2000). **Sometimes the simple act of imagining a different future can free clients from a hopeless perspective, mobilize new ideas, and enable them to construct their own solutions** (Butler & Powers, 1996)**. The supervisor's task in this area might be best described as helping supervisees gain an appreciation for the role of past experiences in shaping a client's present problems, while simultaneously maintaining a focus on the future.** This conveys confidence that clients have the necessary skills, resources, and insights necessary to make that future a reality.

In the final analysis, therapy, like supervision, has a lot to do with helping our charges feel empowered to overcome obstacles and fulfill their aspirations. Of course, with supervisees, it is also important that they know something about the therapeutic process and how change occurs.

Summary

Three different perspectives on supervision have been presented; the consensus views of supervisors, supervisees, and therapy outcome researchers and clients as derived from available literature. Supervisors and trainers emphasize the importance of technical (e.g., perceptual, conceptual, intervention, and relationship) skills and the personal growth of the supervisee as essential to a quality supervision experience. Supervisees appear to agree that these dimensions are important; however, they also value a supervisory environment that is open, flexible, forgiving of mistakes, and responsive to their needs. Furthermore, they want to know both directly in words, and indirectly through the supervisor's actions, that they are respected and valued as colleagues. Finally, the psychotherapy outcome literature reminds us that the client, not the therapist, the theoretical model, or the chosen intervention strategies are at the center of effective therapy. In fact, as much as 55% of variance in therapy outcome has been attributed to dimensions that occur outside of the therapy room altogether or reside within the client prior to therapy, or at the very outset of therapy, in the form of positive expectancies for change. It appears that successful supervision requires both a humility about the role of the therapist (and supervisor) and a commitment to incorporating new ideas and information from a variety of sources as they become available.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

1. **The replication of interaction patterns, content (e.g., theoretical orientation, assumptions about client change, preferred treatment methods), and affect at different levels of the therapeutic system is called:**

   A. Parallel process.

   B. Eclecticism.

   C. Isomorphism.

   D. Supervision.

2. **The ability to translate clinical observations into meaningful language (e.g., applying one or more theories) refers to which of the following skills?**

   A. Perceptual

   B. Conceptual

   C. Intervention

   D. Relationship

3. **According to the psychotherapy outcome literature, which factor accounts for the most variance in successful therapy?**

   A. Extratherapeutic factors, events which occur out side of the therapy altogether

   B. The therapeutic relationship

   C. Therapeutic technique

   D. Positive expectancies and hope

4. **According to the lesson, it seems highly important that the supervisor work with the supervisee to develop an attitude that:**

   A. Conveys a position of authority over the client.

   B. Affirms the therapist as the sole expert who has specific skills and knowledge to guide the client to a successful outcome.

   C. Involves treating clients as capable thus, possessing the strengths and resources necessary to solve their problems.

   D. Values the application of technical intervention strategies that do not take into account extratherapeutic factors.

DIRECTIONS
Volume 11 Lesson 2

Adlerian Group Psychotherapy: A Brief Therapy Approach

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Introduction

This lesson outlines the steps involved in using Adlerian group psychotherapy to help individuals recover a sense of belonging, confidence and a desire for cooperation that can only be inspired by a group. Since Adlerians believe that all human problems are essentially social and interactive in nature, group approaches were a natural development within the model. Adlerian groups have a lengthy history, starting as "Adlerian collective therapy" in the early 1920s (Dreikurs, 1959). These groups have been applied as a brief therapy approach in schools, community agencies, hospitals, family education centers, and in private practice.

In this lesson we will present a step-by-step guide for the conduct of Adlerian group psychotherapy. While no group session follows this model exactly, the basic constructs associated with this structure and process of group therapy are all covered. **After reading this lesson the reader should: understand an Adlerian view of human nature as a foundation and rationale for group therapy; be able to follow group process from formation and psychological investigation through psychological disclosure to reorientation; and understand specific techniques for assessment and intervention with group members.**

Human beings begin life in a group. In most cases, this group is the family, but even in alternative situations, a child needs a group with at least some basic nurturing to survive. The early helplessness of childhood parallels the individual inferiorities of early humans. Adler (1957) was the first to suggest that Darwin's (1976) imperatives for

survival of the species had a concomitant psychological stance in the human condition. In comparison to other animals, early humans had poor eyesight, dull claws, insensitive hearing, and slowness of movement. Humans survived by forming into a herd, dividing the labor, and, eventually, building a community. **The psychological stances that supported this group formation were a feeling of belonging, friendship and support, respect, cooperation, and loyalty: the same things that a child requires to live and grow.**

The family is the first group in which most people must find a place. **Just as the family must adjust to accommodate each new child, each child must develop a unique place and an effective approach to integration within this group. The method chosen begins the formation of the child's self-concept, an interpretation of self and life that will be repeated in patterns over many years. The need to belong will become the strongest single motivating force in human development** (Dreikurs, 1953). As the child moves into new realms (the school, and ultimately the community), this struggle to belong broadens: one's peer group often becomes the strongest influence.

One of the great paradoxes within the human condition is that cooperation within a group does not necessarily imply cooperation between groups: cooperation and competition can exist simultaneously. This can be seen in a positive sense when two sporting teams take the field, each team cooperating as a unit or group while competing with the other. It can also exist in a negative sense: two inner-city gangs at war, for example, or when a group experiencing discrimination bonds together, but simultaneously discriminates against another, perhaps one less fortunate. This paradox in group process is sustained by freedom and a political democracy, since totalitarian states that prize order seek to control subsytems and groups within society.

Political freedom seeks its fulfillment in the social equality of a democracy. Social equality — the right to be different, but equally valued and respected — coupled with freedom and democracy, always augment options and increase the fluidity of individual movement between socioeconomic strata. Education and technology are the means by which both individual and group options are most often actualized. An increase in personal freedom and social equality, however, does not imply that people are prepared to handle these benefits or their effects. **Where order and placement in a group are no longer predetermined, each individual must struggle with multiple possibilities to create a place for themselves.**

People who do not feel up to the essential tasks of life: getting along with oneself, forming friendships with others, making a contribution through work and occupation, or finding love, creating intimacy and extending the family; often retreat from perceived group and societal demands into neuroses (Adler, 1996)**, depression, anxiety, behavioral disorders, and even the psychoses.**

Children do not tend to start life in retreat. On the contrary, children start life with a natural propensity for growth and development enacted within the structure of the family. It is not news that dysfunctional families often produce problem children, but even in the most dysfunctional of families, some children find a way to survive, grow, and create a meaningful life for themselves.

Children are active agents in life, not merely life's passive recipients. **The child's interpretations of self and others will have greater predictive validity than the conditions in which the child is raised.** We can say that each child both influences and is influenced by the members of his or her family—before moving on to other groups in which the child will again exchange influences. People may change the groups with which they associate many times over a lifetime. In each case, they will leave their mark, and they will change. The impact of the group on the person is easily observed whenever the individual participates in that group. **The use of the group to influence individuals not only constitutes an effective means of teaching, but also an effective way to offer corrective influences** (Dreikurs, 1957).

Every time democracies begin to emerge, group methods in one form or another come into vogue. Socrates used a form of group counseling with youth that consisted basically of reorientation by means of well-framed questions. Aristotle was aware of the cathartic effect of theater for the group of participants, and for the audience (Copleston, 1959).

In the twentieth century, group psychotherapy co-developed with the psychological professions. It had its beginning in Europe at the turn of the century, and it reached its peak in the two and a half decades following World War II. During this same period, every time a country retreated from democracy (into totalitarianism), group therapeutic procedures were abandoned: this happened in much of Europe during the World Wars and in Eastern Europe with the formation of the (former) Communist bloc (Corsini, 1955; Dreikurs, 1959). It is not surprising, therefore, that group process and practice has developed most rapidly in the United States, **for not only does group process require a democratic atmosphere, it creates one** (Sonstegard, 1998).

Adler appears to have been the first psychiatrist to use group methods deliberately and systematically in his child guidance clinics in Vienna, starting in 1921 (Hoffman, 1994). Further, Rudolf Dreikurs (1960) may have been the first to use group psychotherapy in private practice, starting in 1928 (Terner & Pew, 1978). Both of these pioneers developed and used group methods in an effort to reach a greater number of people in a shorter period of time. In this sense, Adlerian group psychotherapy has always been a brief therapy approach.

> **Adlerian brief therapists bring focus to the change process, often using each session as though it is the only session they have to make a difference. There are two foci that guide every session. The first seeks to develop a systemic and holistic understanding of the people involved in treatment, including their rules of interaction. The second seeks to understand the goals the [clients have] in seeking help. (Bitter, Christensen, Hawes, & Nicoll, 1998, p. 96)**

Human beings are both hermeneutical and teleological. It is the human necessity for interpretation and reflection that creates meaning and self-understanding in life. It is not our past that determines who we are, but we who determine what our past has been, what it means, and to what extent it will be the context for our present and future. And it is the future we intend or fear that motivates us, that unifies our actions, movements, and approaches to life. Adlerians believe that every thought, feeling, value, conviction, and behavior are in line with our central goals, the purposes we intend for our lives (Ansbacher & Ansbacher, 1956).

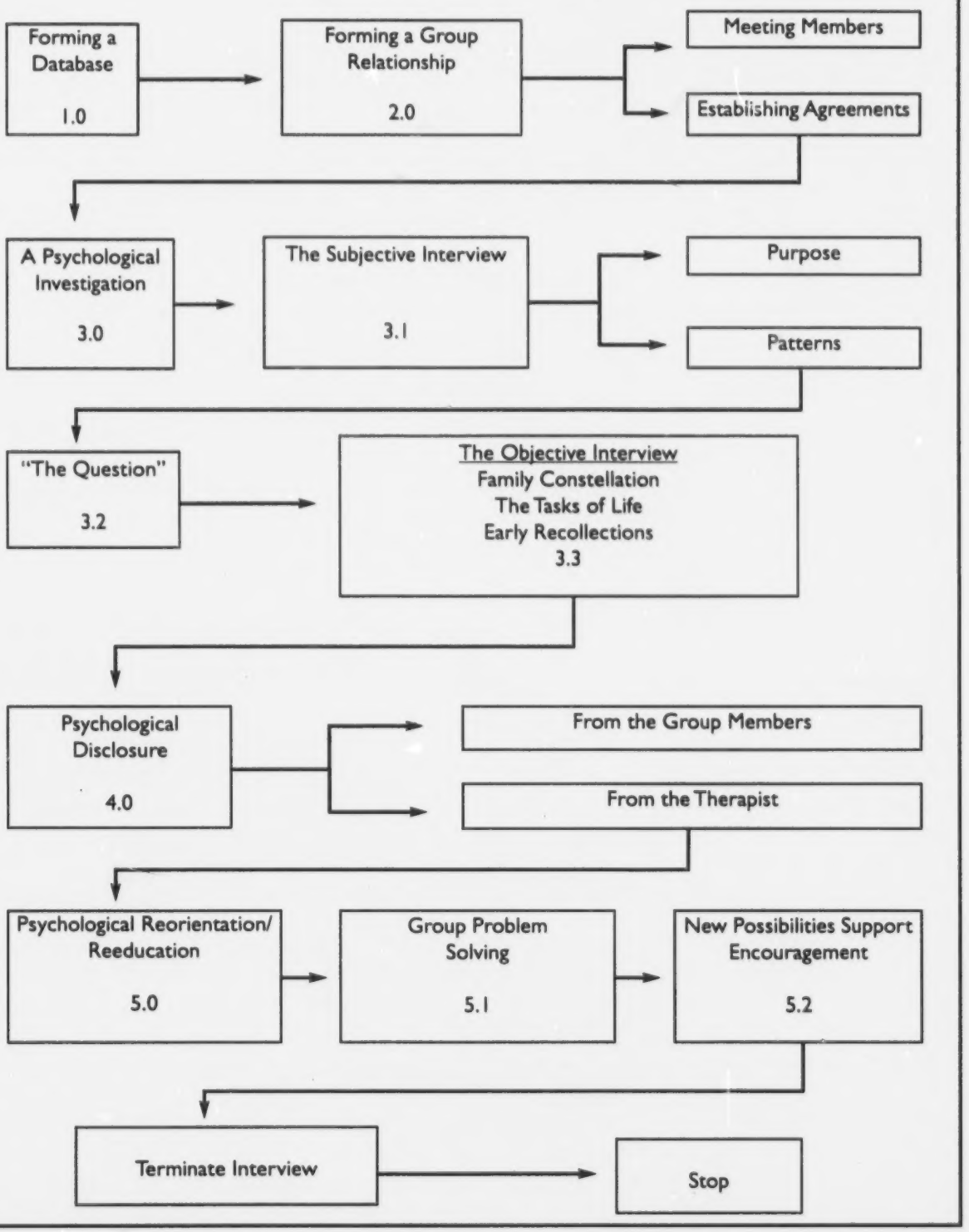
Human beings are also social beings, again by necessity. **Human mental health finds both its foundation and its salvation in a movement toward others. Adlerians believe that people simply do better when they have a sense of belonging, are less self-absorbed, and have friends and family to whom they make a contribution and with whom they feel needed and valued.** Such people have what Adler called a "community feeling" and the "social interest" that extends from that feeling (Ansbacher, 1992). Such people approach life with optimism, courage, and often a sense of humor.

Nothing tests a person's community feeling/social interest more than group process and group dynamics. People can take any position that suits their purposes in individual therapy or one-to-one interactions. In groups, however, all of the demands of life are reconstituted. One's sense of well-being, one's interest in others, and one's preparedness for human contact and social connection are all demonstrated. In groups, people must interact, and their interactions will reveal their confidence or hesitations, their courage or retreat, their willingness to take reasonable risks and their needs for safety. **People both discover and create who they are in groups. Life's problems are enacted in groups. And except for the most severely disoriented clients, group psychotherapy provides the treatment modality that most parallels human life.**

Adlerian Group Psychotherapy: Step-by-Step

Adlerian group psychotherapy is an approach within an overall approach we call Adlerian Brief Therapy (Bitter & Nicoll, 2000; Bitter, Christensen, Hawes, & Nicoll, 1998). The model for group psychotherapy is presented in Figure 1, which is a guide and summary tool for therapists-in-training. Adlerian group psychotherapy is an integration of Adlerian psychology with socially constructed, systemic, and brief approaches based on the holistic approach developed by Rudolf Dreikurs (1960; 1997).

Figure 1
ADLERIAN GROUP PSYCHOTHERAPY: STEP - BY - STEP



Creating a Database

Information about clients and potential group members is often available to group practitioners, either through intake processes, referrals, or prescreening interviews. An early database can often help a group therapist to form initial guesses about the group, hypotheses that will later be confirmed or discarded. Adler was a master at constructing an initial assessment from data gathered by others (See Adler, 1970, "The Case of Mrs. A."). His hypotheses were often so accurate that an initial meeting with clients immediately confirmed his guesses. Whether confirmed or discarded, however, the act of engaging in an early assessment orients the therapist psychologically.

While the prescreening of group members is common today (and even a requirement in some professional codes, e.g., ACA, 1995, ASGW, 1989), **Adlerians typically reject this procedure. While we have no objection to pregroup meetings that provide potential group members with information about group process and dynamics and help them to establish goals for the experience, prescreening is too often used to eliminate from a group the very people who could most benefit from the experience** (i.e., those who are disruptive, self-absorbed, or isolated).

Even if a member of a group were to experience an active episode of psychosis, "hearing voices" for example, it is still possible for the group to both learn from the experience and provide the support needed for recovery. Similar to the investigations of the narrative therapist Michael White (2000), Adlerians are interested in what meaning these voices have in the person's life; what purposes they intend for the individual, how the voices orient the person toward or away from others, and if the intentions of the voices are the goals that the person has for him or herself. These are all issues that can be addressed in a group and can help the person to recover a sense of value and belonging. Even if we knew a group member had the potential for a psychotic episode, most Adlerians would not want the person eliminated from group in a prescreening process. Indeed, we would prefer to work with that individual in a group of fellow human beings.

The reality of community mental health, whether residential or outpatient, and the controls of managed care usually negate the opportunities for prescreening of group members anyway. Groups are often formed as a part of ongoing treatment programs, and the members of these groups change intermittently with the flow of client populations. In many cases, initial data will barely provide the therapist with enough information to facilitate the integration of new members.

Forming a Group Relationship

For groups to get off to a smooth start, it is important for the group leader to address certain logistics, (e.g., size, location, and balance of group members). Most of these issues require the therapist to reflect on what would constitute "optimal conditions" (see Yalom, 1995). Start by asking these questions:

- **How many people can the therapist maintain contact with for an hour or more?**
- **Is there a location available that is private, has good lighting, and is free from distractions and noise?**
- **What balance of men and women, of which ages and cultures, or of homogeneity versus heterogeneity, is needed in the group?**

Assuming these logistic questions can be adequately answered, most group psychotherapy sessions take place in a moderately comfortable setting with chairs placed in a circle. If group members begin to take their places before the session begins, it is not uncommon for some informal introductions to occur—and some early alliances may even start to form.

Two of the authors had the privilege of studying with the late pioneer of family therapy, Virginia Satir (1983). She taught us that within everyone who is having difficulty coping is a person who "would use himself or herself differently if he or she were in touch with the life that he or she is and has" (p. 246); especially if the person were able to tap all the potential that comes with enhanced self-esteem. Like Satir, Adlerians believe that all people can be reached and that the avenues for reaching people, though idiosyncratic, are all characterized by human contact, mutual respect, and a presence that includes interest in, care for, and faith in others.

Like Adler, Satir (1983) believed that people could not help but express the patterns and purposes that constitute and permeate their lives.

> **. . . I am listening to their responses to me. In a few moments, I will hear responses from the people to each another (sic). I begin to get a feeling for what they have done, how they have used their experiences from the time they popped out of the womb until now. (p. 247)**

Meeting Members:

Therapists must learn to begin group process with this kind of presence and interest in the people they meet, and they must learn to concurrently observe the group as a "process" entity. A number of questions facilitate observing the group in this way:

- **Who sits with whom?**
- **How do people enter and find a place in the group?**
- **Who talks to whom?**
- **What is the level of comfort or discomfort in the room?**
- **What kind of atmosphere seems to be present?**
- **What initial impressions are being formed?**

When everyone is present, we catch everyone up on how the group was formed and on any hopes or desires we have for the group process, and then we ask the group members to briefly introduce themselves.

We often ask children and adolescents to meet first in pairs, learn something about each other, and then bring this information back to this group. This process gives those who are struggling to find the "voice" they want to use in the group a chance to practice in a dyad first.

> ***Therapist**: I think I am the only one who knows everyone here. Each person, here, shares some hope for better contact with others, and it is my hope that this group will provide an avenue for realizing that goal. Why don't we start by choosing a partner to interview so that you can introduce them to the group. You may want to tell each other your names and something you would like others in here to know about you.*

By focusing on ***relationship*** from the very beginning, we are laying a foundation for cohesiveness and connection. While these initial introductions are important, they do not have to take the entire session or even a major portion of it. Introductions are a chance for group members to break the ice, to use their 'voice, perhaps for the first time, in a group setting. When group members have had a chance to introduce themselves, we generally ask them what agreements they would like to have in the group.

Establishing Agreements:

As much as possible, Adlerians want group members to establish their own agreements for the group experience. We do not use the concepts of group rules or even ground rules, terms that suggest and too often reflect our authoritarian history and the superior/inferior relationships inherent in that history. **Younger group members, especially adolescents, must feel that they have contributed to the development of the group process.** Below, we have provided an excerpt from the first session of an adolescent therapy group.

> ***Therapist**: What agreements do we need to have to make this group work? [A long pause]*
>
> ***Karen**: Well, how often should we meet?*
>
> ***Therapist**: How often do you think we should meet? How often would you like to meet?*
>
> ***Hugh**: Wouldn't that depend on the problems we bring up? We might need to meet three times a week.*
>
> ***Therapist**: [clarifying] Three times a week?*
>
> ***Hugh**: Maybe.*
>
> ***John**: I think three times a week is a little too much. Maybe once a week, maybe not that often.*

***Beth**: I think if someone has a problem they want to talk about they should get in contact with the others, and we could talk then.*

***Therapist**: [to Beth] How often do you think we should meet as a group?*

***Beth**: As a group? Do you mean a regular planned meeting?*

***Therapist**: Yes [nodding].*

***Beth**: I think once a week would be enough.*

***Erv**: We could have emergency meetings if we needed them.*

***Therapist**: So once a week. Are all of you okay with that? [pauses as he looks around at group members] Now, how long do you want each group session to last?*

While these decisions seem rather basic, they give some control over the group structure to the group members, and they lay the foundation for dealing with more important issues. Is the group open or closed? Can members come and go as they please, or do they always need to be present? Can a group member choose to be silent, to observe, and not talk? What will the use and limitations of confidentiality be, and how will this essential concept be defined. Again, continuing with the same group:

***Therapist**: How about if we get to talking about really personal things? We bring them out in the open and discuss them in the group: do you think there would be any danger in that?*

***Hugh**: It might be a good idea, but I would have to feel safe in here, and I don't automatically.*

***Therapist**: Well, suppose that some members of the group discuss what you say with people outside of the group.*

***Karen**: That would be bad.*

***Therapist**: What will be the safeguard against that?*

***Beth**: Just take a vow or something that we won't talk about anything outside the group.*

***Therapist**: Do vows work for you?*

***Beth**: Not always.*

***Karen**: It's hard though. If I can imagine myself talking outside the group—even a little—then I think that others would.*

***Beth**: But if someone asks me something, my parents or friends or something, I could see telling people a general topic we discussed.*

***Erv**: I could live with that.*

***Therapist**: If someone asks then, we can say that we talked about such and such, but not that Karen said this or Erv said that. That last part would cause mischief, maybe even harm.*

A Psychological Investigation

Adlerian psychological investigations focus on personal patterns and motivations expressed and enacted within the group and the social contexts experienced by individual group members. While most such investigations start with a ***subjective interview*** that allows group members to bring up various issues, Adlerians may introduce more objective inquiries, including ***The Question***, or by going directly into the ***objective interview*** with questions about family constellation and/or birth order, an evaluation of the tasks of life, or early recollections, to name a few. These will be discussed in more detail below. Initially, what members choose to discuss in group can be completely open. It is often enough to start by asking, "So what should we talk about?" With adolescents and younger children, we occasionally let the group members know the range of topics that have been discussed before: "I want you to know that I am open to discussing anything that is seriously important and relevant to you. In the past, groups have talked about family difficulties, sex, drugs, school problems, feeling hopeless or alienated . . . anything, really." When group leaders open with such an invitation, they must be prepared to be tested on the integrity of their offer, but whatever the topic chosen, listening to each person's storyline, interaction processes, and group contributions will always reveal individual patterns and motivations.

The most common Adlerian interventions during an initial psychological investigation of the group include:

- **Asking group members to provide the group with specific incidents to which the person attaches meaning.**
- **Asking group members how they feel in the midst of specific interactions.**
- **Watching the effect of individual contributions on the group as a whole.**

A group member who complains that her parents are hopeless and that she can't talk to them opens an investigative door, but very little is known from the complaint itself. "When was the last time you tried to talk to your mom or dad and it didn't work out? How did that attempt go?" Her answer to such a specific inquiry reveals her process and her perception of her parents' reactions; her answer will suggest the start of a pattern that she uses in attempting to make contact with significant others. Further, the reaction of these significant others is often the very reason (purpose) for which the person initiated the pattern in the first place. "And how were you feeling when this was going on?" The group leader gets to hear the reactions of the group member, and more importantly, a hint of the interpretations about self and others that the person assigns to the event. If a pattern can be identified, it then becomes a guide for understanding possible interactions in the group itself.

The Subjective Interview:

A subjective interview seeks to develop both individual storylines and a group consensus about what is relevant and important to most of the members. Finding a common language of inquiry often is a first step in this process. Karen may start by saying, "I know one thing that has been bugging me lately." What bothers her is important, but so is the language of "being bugged." The group leader will want to acknowledge what "bugs" Karen, and also bring the rest of the group along: "Karen says the attitude of teachers bugs her. What bugs the rest of you? Hugh, what bugs you?"

Balancing the development of individual storylines with the need for group interaction is critical. Finding or asking about commonalties that exist in the presentations of multiple members also helps to build a sense of cohesiveness in the group. Even if group members do not have similar life experiences, they can be asked to speculate about what meaning individual stories might have for the person telling it. What seems to matter to the person? What does it say about the storyteller? What goals or purposes seem to motivate the person?

Often group members will say things that seem on the surface to be contradictory. For example, Erv might note that he "tries to please his parents," but he also "gets angry at them and explodes." Adlerians treat such statements as two points on a line. In effect, we want to know how both of these statements can be true. What are the steps that get Erv to move from one position to the other, and what does this tell us about what motivates Erv? In the above example, the steps might be: (1) Erv works hard to clean up the garage, as his parents have been asking him to do; (2) Erv wants to be appreciated for his effort; (3) his parents fail to notice, or worse, they point out the parts he didn't do so well; (4) Erv decides "if they don't appreciate me for what I try to do, I will really give them something not to appreciate; (5) at the next opportunity, he arranges to get angry at them and explodes.

"The Question" :

Adler (1927) used to ask his clients "What would you be like if you were well?" Dreikurs (1997) adapted what came to be known in Adlerian circles as "The Question" in the following manner: **"What would you be doing if you didn't have these symptoms or problems?" or "How would your life be different if you didn't have these symptoms of problems?" Dreikurs used "The Question" for differential diagnosis: When a group member said, " I would be doing better in school or have more friends if it were not for my anxiety," Dreikurs believed that the client was using the anxiety as an excuse for not succeeding or for lacking friends.**

That is, the client was in full retreat from the anticipated failure that would presumably occur if she or he

attempted to make a better life. In this sense, clients do not propose a desired outcome or solution to life's problems when they answer "The Question"; rather, **their symptoms are their solutions—mistaken ones, to be sure—that help people to avoid life tasks and responsibilities that are perceived as necessary.** Of course, it is possible that clients might answer that nothing would be different, except that the anxiety would be gone. In such cases, Dreikurs suspected that the pathology or symptom was most likely organic.

The Objective Interview:

Many Adlerian therapists will skip the objective interview when they have developed enough of an understanding of the people in the group from the subjective interview. Standard Adlerian assessment processes include information on members' family constellations, personal approaches to what Adler (1957) called the life tasks (e.g., friendship, occupation, and intimacy), and interpretations of each individual's early recollections. Some therapists use one or more of these assessment tools to confirm what they already suspect about member patterns and motivations. Some therapists, however, prefer a more intensive process called a lifestyle assessment (see Powers & Griffith, 1987, 1995, or Shulman & Mosak, 1988). **Allowing for variations in style, it would be unusual for an Adlerian therapist to not introduce some aspect of this objective interview into one of the early sessions of the group.**

John: *It's just been mounting up this year. I'm a junior this year, and I'm active in dramatics. Doesn't seem like I'm home that much. I'm gone a lot. Home to eat and sleep mainly. But, anyway, they get on my back about it. And I don't see why; I'm doing okay in school.*

Therapist: *How many brothers and sisters do you have, John?*

John: *I have one brother and one sister. I 'm the oldest. I'm 16. I have a sister, 12, and a brother, 10.*

Therapist: *Now, how do your parents deal with your brother and sister?*

John: *They seem to do better with them. Seems like I am the black sheep of the family. They understand them better. I'm always doing things they don't like, and they take it out on me. That's the way I feel. Seems weird to just be saying that, but it's true.*

John was four years old when his sister was born. Perhaps he felt that he lost his favored position in the family with her birth. John has always had some interest in the attention of others. Even as a teenager, his interest in drama places him on a stage where positive attention is possible. When his sister was born and the family attention necessarily shifted to the newborn infant, John may have tried the usual antics that children use to keep mom or dad busy. Before his sister, this would not have been much of a problem, but after her birth, perhaps a harried parent loses his or her temper, even punishing John, the eldest, thereby confirming his loss of status in the family. To add insult to injury, the parents have a third child as John is starting school. The two siblings will be quick to sense the parents' disapproval of John's behavior, and each will adopt behaviors more acceptable to mom and dad. As John gets older, he comes to believe that there is no hope of winning over his parents, so he stays away from them as much as possible.

John's storyline is a narrative of the psychological conclusions John has reached about his life. The therapist posits this tentative understanding based on an assessment of family constellation, the manner in mood in which John presents the data, and his style of interacting in the group. Considering the requirements of both tact and timing, the therapist might choose to use the information only as a guide for alternative interventions, or, if appropriate, present the narrative to the group as a tentative guess for group consideration. Appropriateness for the group and John's openness to new information are essential considerations.

Family Constellation

An assessment of family constellation allows the therapist to identify:

- **Major influences in the client's life.**
- **Interpretations the client generates about his or her position in the family.**

- **Experiences the person had with parents that set a guideline for gender identity.**
- **Interpretations of life and society offered by the parents.**

Within this assessment, the client's phenomenological interpretation of birth order is essential, since across cultures, siblings tend to have a greater influence on personality development than parental involvement (McGoldrick, Watson, & Benton, 1999. **Listening to each individual's sense of place in the family helps the therapist to understand the client's overall sense of place in the world.**

Life Tasks

An assessment of life tasks allows the therapist to:

- **Discover coping patterns that individuals use to handle life's problems.**
- **Look for areas of support and dysfunction in daily living.**
- **See the extent to which group behaviors manifest themselves in other parts of people's lives.**

Friendship is really a social task that is essential for cooperative living. How many friends a person has, what position he or she has with these friends, and what the person offers to and wants from friends all have a significant impact on quality of life: this task often helps to answer the questions we have about who we are.

Occupation is really about how we use our time. What do we do and toward what end? What contributions do we intend to make? When life is finished, *what will we be worth?*

Intimacy has to do with what kind of closeness we want in our lives. Often it includes how well we get along with members of our own gender and the other gender: what it means to us to be a man or a woman. It is related to the contribution we want to make in continuing human life beyond our own existence.

Early Recollections

Adlerian therapists use early recollections for different purposes, including:

- **An assessment of each person's convictions about self, others, life, and ethical stances.**
- **Assessment of members' stances in relation to the group process and the counseling relationship.**
- **Verification of coping patterns and motivations.**
- **Identification of strengths, assets, or interfering ideas or mistaken notions in each person's life.**

Because Adlerians use early recollections as a projective technique (Mosak, 1958), we tend to introduce them with an open-ended request: "Think back to when you were very little, and tell me something that happened to you one time." Most people have between 6 and 12 early (age 8 or younger) memories; these memories are self-selected stories that the individual uses to maintain a sense of constancy about self and life (Adler, 1927, 1957). The content in memories is not as important as "why" the client has them. The client's life position in the memory is often revealing as is thinking about the memory as a story with a moral (a specific meaning). Interpretations are achieved collaboratively within groups with group members offering guesses about possible meanings. In the end, each person must agree with or recognize the interpretations that have personal meaning.

Psychological Disclosure

Psychological disclosures might happen at any point in the group process. While initial disclosures tend to come from the group leader, it is important to involve group members in the process as soon as possible. The group is invited to investigate meaning in each other's lives as a foundation for working with each other and considering desired changes. Psychological disclosures are used to:

- **Create understanding by making unconscious processes conscious.**
- **Confront useless interactions in the group.**
- **Explore possible motivations behind behaviors.**

All behaviors, feelings, values, and convictions have a purpose that is social in nature. Understanding the social results of a member's behavior is the easiest way to discover goals and purposes. Disclosures may also follow from any of the assessments that are part of the objective interview described above.

Erv: *I can't stand it when my dad tells me what to do. He really doesn't ever know what he's talking about, and he never listens to anybody else. I just love it when he messes up. Especially if I'm in a position to say I told you so.*

Therapist*: Erv, can you think back to when you were little? Do you remember something that happened one time?*

Erv*: Anything? [Therapist nods.] Well . . . I was in the first grade, and this college student came to give me an intelligence test. He had to practice or something. And he wanted me to put this puzzle together, but even with the manual he couldn't do it himself. So I watched him struggle for awhile, and I, like, figured out how to do it. So I took it from him and just did it. I sat back and felt great. I was smarter than he was.*

Therapist*: What do the rest of you think this might mean to Erv and how does it fit with what he has been talking about?*

A number of different interpretations were offered by group members, but the one that seemed to fit best for Erv was also the most blunt and direct.

Kathy*: I think Erv feels he is superior to most everyone else, and he always has to demonstrate that he is right and others are wrong. It's how he stays superior.*

Though strongly worded, Kathy's interpretation made the most sense to Erv. He could almost immediately identify other events in which this meaning was present. Another reason Erv could accept Kathy's interpretation is that it came in a tone of voice that contained no indication of criticism or negative judgment. In general, interpretations that come from group members tend to have more impact than those that are offered by counselors or therapists. Had an Adlerian therapist decided to add a guess to the process, Dreikurs' (1961) formula for psychological disclosure would commonly be used:

- **"Do you know why you (feel, behave) as you do?"**
- **"I have an idea. Would you like to hear it?"**
- **"Could it be that . . . ?"**

Psychological disclosures offered tentatively, as guesses, invite collaboration within the group. In this sense, even incorrect guesses have value. They demonstrate that the therapist is willing to even risk being wrong in an effort to understand. Further, the elimination of an incorrect guess often leads to a better interpretation and allows group members to experience mutual respect in the therapy process.

Psychological Reorientation and Reeducation

Psychological reorientation is about changing group members' stances in life. It is about helping people to cope and to approach life's tasks in a useful manner. Adlerians define this usefulness as:

- **A sense of belonging and feeling valued inone's community.**
- **A movement away from self-absorption, withdrawal, isolation or self protection toward the development of a community feeling and social interest.**
- **The enactment of traits commonly associated with a community feeling, such as courage, the acceptance of imperfection, confidence, a**

> **sense of humor, a willingness to contribute, an interest in the welfare of others, and a friendly approach to people (Ansbacher & Ansbacher, 1956; Bitter & West, 1979).**

Sometimes, psychological reorientation is accomplished through reframing, a modification of motivation, the creation of new meaning, or the development of new possibilities and options.

Group Problem Solving:

In group psychotherapy, however, group problem-solving tends to be the most common intervention. Successful group problem-solving depends on and flows from having established a psychological understanding of self and other people involved in any problem.

Returning to John, a young man in the group who either fights with his parents or stays away from home because he feels he has no place in his family, the therapist asks: "Now, what do you think John could do about his situation?"

***Beth**: Well, I don't think he should start doing what his parents tell him, because that would only frustrate him, but . . .*

***John**: Well, I didn't plan on it anyway. [laughter]*

***Therapist**: Are you interested in doing anything about it or would you like to keep on fighting them?*

***John**: I don't like to fight them. But it does seem like they think they're always right, and I'm always wrong. And I just do stuff to get them ticked off and prove to them . . .*

***Therapist**: . . . to prove to them you have power.*

***John**: Yeah, right. [pause] Well, they have a little bit.*

***Therapist**: [smiling] You have to give them some credit. Very magnanimous of you.*

***John**: I let them have a little.*

***Erv**: Otherwise, where would you eat or sleep.*

***John**: I like to be charitable.*

***Therapist**: But it bothers you a bit. You say you don't like to fight, but power is a means for you to have a place. You think, "If I am not powerful, then I am nothing." [Turning to the group] And nobody can stand to be nothing. So he uses this maneuvering of parents—setting them up and then defeating them—to find a place. But it's a useless way of doing it. Would you agree that it's a useless process?*

***Karen**: Yeah, but if you don't do something you get pushed into a corner.*

***Therapist**: In other words, you feel you should stick up for your rights. [Karen nods]*

***Hugh**: I don't know. I think parents have some respect coming to them. You need to show them some respect, but the way John does it, I don't know. Maybe doing something for your parents now and then.*

***Karen**: I don't think that just because you're a parent you naturally should get respect from your children. I think you should earn it. They expect me to earn it from them, and I want them to earn it from me.*

***Beth**: If parents don't respect kids, that isn't teaching kids respect. My parents have always been the authority, had all the responsibility, and they don't know what to do otherwise.*

***Therapist**: What could be done to help the situation?*

***Beth**: Sometimes I go into the living room and say, "I have something to say, and I need you to turn off the TV and listen." And they usually do.*

***Therapist**: Do you think John could do the same thing?*

***Beth**: He could try.*

***Therapist**: It worked with you. Nothing works perfectly all the time, but maybe it's worth a try. [pause] What else might John do?*

***Hugh**: Well, maybe if John begins to feel he has a place just because of the person he is—and he doesn't have to have power to feel important—maybe this will help.*

***Therapist**: Anything else?*

***John**: Maybe if I do something for my parents every now and then, it wouldn't hurt.*

***Therapist**: Yes. Sometimes, when parents feel a little more appreciated, they change a bit. This is a difficult thing to learn. If we want to change someone, we are the ones who have to change first. [pause] Well, this seems like a natural place to stop for today.*

In the above example, John's concern has been noted and the group leader suggests the possibility that group members might be helpful in seeking solutions. Group problem solving and the generation of new possibilities tend to go hand in hand. In a sense, the steps in group problemsolving have been part of the group process from the beginning. They include:

- **Establishing an atmosphere of safety and mutual respect.**
- **Clarifying a psychological understanding of the group member's interactions.**
- **Asking the group member if he or she is open to input from others.**
- **Generating as many options as possible.**
- **Identifying a constructive possibility that seems to fit for the client.**

In the end, John indicates which of the possibilities suggested seems to fit for him: "Maybe if I do something for my parents every now and then it wouldn't hurt." The enactment of new possibilities almost always requires suppport and encouragement. It is not uncommon for Adlerians to use role playing and other psychodramtic techniques to aid group members in the practice of proposed solutions (Corsini, 1966). Support and encouragement also come in the form of having a group of peers "standing in your corner" and believing in you. Being part of a group also means that you never have to experience success alone: therapy groups are ideal places in which to celebrate member successes.

While most group sessions seem to arrive at a natural stopping point, it is one of the tasks of the group leader to be cognizant of time and to not generate new material or processes when it close to the end of the session's work. Indeed, even though most groups are ongoing, Adlerians treat each group as an entity in itself; that is, the group process for the session may serve a goal or purpose, propose or complete some work for one or more group members, or facilitate a new learning or meaning. Summarizing the achievements of sessions lays the groundwork for the eventuality that the group, itself, will one day terminate.

Many groups are part of agency offerings that continue even with group members entering and leaving at irregular rates. While not always possible, Adlerians seek to honor these comings and goings by noting changes in the group, introducing new members, and acknowledging the importance and loss of group members when they are getting ready to leave. Groups that have been formed for a given purpose are usually time-limited. Such groups will need one or two sessions to reach closure, to value the experience, to complete unfinished business and to develop referrals and follow-up meetings for those who may still need help and support.

Some time-limited groups explore the possibility of meeting on a short-term basis again in six months or a year. This process allows the group members a formal way to check in with each other and to further mark progress in their lives. When structured with formal follow-up meetings, Adlerian group psychotherapy may never officially terminate. It is merely "interrupted," a form of brief, intermittent therapy (Bitter & Nicoll, 2000, p.38).

Summary

Group psychotherapy seeks to make a difference by generating new possibilities, offering support, and providing encouragement. The word encouragement literally means "to build courage," and it stands in direct opposition to discouragement. In general, Adlerians believe that courage is built from strengths, from a sense of "being a part of," and from getting in touch with both internal and external resources. Groups have great potential for providing all of these ingredients. Encouragement flows from the faith group members come to have in each other, from the hope that comes from group support, and from a communication of caring that often comes from both group members and the therapist. Properly tended, groups become what

Miriam Polster (1999) call a "safe emergency" (p. 107), a place to try new possibilities and to consider new options. Groups invest social interaction with real meaning, because groups will not only help an individual member, but will also evoke in that member a desire to help others. And immediately, we know two things: (1) the group member offering help has already found a place in the group and may be on his or her way to finding a place in the larger world, and (2) the help offered reflects an increase in social interest and self-esteem.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

5. **Adlerian group psychotherapy is a brief therapy approach that is based on which of the following assumptions:**

   A. In order to be beneficial, groups both need and create a democracy.

   B. Humans are both hermeneutic and teleological in nature; it is the future we intend or fear that motivates us.

   C. A community feeling and social interest stand in opposition to isolation, withdrawal, retreat from life's tasks, and self-absorption.

   D. All of the above

6. **Which of the following is *not* a necessary step in Adlerian group psychotherapy?**

   A. Prescreening group members.

   B. Forming a group relationship and reaching initial group agreements.

   C. Conducting a psychological investigation of group members.

   D. Initiating a psychological reorientation/reeducation process.

7. **Adlerians generally consider an assessment of family constellation, life tasks, and early recollections to be part of:**

   A. A pre-group assessment.

   B. A subjective interview.

   C. An objective interview.

   D. An encouragement process.

8. **Adlerians use group psychotherapy as a common treatment of choice, because:**

   A. Most human problems are sociopsychological problems that can best be solved in a group setting.

   B. Groups, properly led and tended, can provide clients with a safe place to try out new possibilities and options with others.

   C. Groups not only help the individuals who make them up, but also evoke in those members a desire to help others.

   D. All of the above

DIRECTIONS
Volume 11 Lesson 3

Substance Abuse Treatment for Pregnant and Parenting Women

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Introduction

Substance abuse treatment and research addressing the needs of pregnant and parenting women is a relatively new phenomenon (Finkelstein, 1993; Zuckerman, 1994). Historically, women who abused alcohol and other drugs, particularly during pregnancy, were greatly stigmatized (Finkelstein,1994). Many feared criminal repercussions or the loss of their children if they sought treatment (Edelstein & Kropenske, 1992). Within the last two decades gender-specific treatment has evolved philosophically and programmatically (Kumpfer, 1991). **The field of substance abuse treatment, which previously focused almost exclusively on men and concentrated on behaviors related to substance use, has expanded to encompass treatment programming that addresses the personal and family needs of women (Burman, 1992).**

This lesson discusses issues related to substance abuse in women, highlights gender-specific substance abuse treatment programming, introduces a group therapy treatment model, and describes a loss and grief group therapy model. A case study of one client's experience illustrates the approach taken in a successful loss and grief group. The lesson concludes with a summary of key points.

Substance Abuse in Women

Drug use among women, particularly those of childbearing age, 12 to 44 years, is a critical health and mental health issue. Women from all racial, ethnic, and socioeconomic groups use both illicit and licit drugs (SAMHSA,1994). Estimates from the National Household Survey on Drug Abuse indicate that women in this age group account for approximately 45% of illicit drug use in the United States (SAMHSA, 1996). While reported substance use rates for women are continually lower than those for men, the differences have lessened over time (SAMHSA, 1997). Based on extrapolated statistics, approximately 200,000 women died as a result of substance-related illnesses in 1994 (Blumenthal, 1998). Substance use by women has repercussions on family members. It is estimated that more than 1.6 million women using drugs were living with their children. Maternal substance abuse affects the children biologically, through prenatal substance exposure, as well as environmentally (Brooks, Zucherman, Bamforth, Cole, & Kaplan-Sanoff, 1994). The environmental impact results not only from the drug use itself, but also from factors secondary to drug use, such as inconsistent caretaking and increased violence (Smith, 1992). The children of women who use drugs are at high risk for emotional, developmental, and academic sequelae (Vincent, Poulsen, Cole, Woodruff, & Griffith, 1991).

Although substance-abusing women usually have a drug of choice (i.e., one drug that they use predominantly), current research has identified that many are polydrug users (i.e., they use different drugs in combination). For example, a woman might use both cocaine and alcohol, or heroin and marijuana. **It should be kept in mind that women who abuse drugs may use both illicit substances** (e.g., cocaine, crack, heroin, amphetamines) **and legal substances** (e.g., alcohol, cigarettes, and prescription drugs; SAMSHA, 1994).

The development of the field of gender-specific treatment has led to research and an understanding of the special needs of defined groups of women, including lesbians and homeless women, as well as women from various cultural backgrounds, such as Native-American, African-American, European-American, Asian-American, Latina, and Pacific Island women (Orlandi, Weston, & Epstein, 1992). As our clinical and research understanding of the specific needs of women becomes more defined, interventions appropriate to their needs are increasingly becoming implemented.

Health Status:

Women who abuse substances often exhibit greater health needs, particularly gynecological and obstetrical needs, than women in the general population, and they appear to be predisposed to more medical problems than male substance abusers (Drabble, 1996; Comerford, Chitwood, McElrath, & Taylor, 1998; Daghestani, 1989). In addition to the direct physiological effects that alcohol and drugs have on women, sexually transmitted diseases (including syphilis, chlamydia, and HIV) and tuberculosis are serious health concerns (SAMHSA, 1994). The effects of substance abuse on women's health is complex due to a variety of factors. Their poor health is related to unhealthy lifestyles including prostitution, living in violent environments, poor nutrition, and little consistent health or dental care, either prevention or treatment (Comerford, Chitwood, McElrath, & Taylor, 1998). As a result, they often enter substance abuse treatment in poor physical condition.

Psychosocial Status and Mental Health Issues:

Understanding the psychosocial characteristics of women seeking treatment for substance abuse is important for treatment planning and treatment effectiveness (Hagan, Finnegan, & Nelson-Zlupko, 1994). **Many women enter treatment with dual diagnoses** (Grella, 1997; Schinka, Hughes, Coletti, et al., 1999), **which frequently include affective disorders such as depression** (Griffin, Weiss, Mirin, & Lange, 1989; Wechsberg, Craddock, & Hubbard, 1998), mood disorders, and posttraumatic stress disorder (Kilpatrick, Resnick, Saunders, & Best, 1998). It has been noted in many studies that women in treatment have low self-esteem and this has proven to be an important treatment consideration (Marr & Fairchild, 1993; McComish, Greenberg, & Kent-Bryant, 1999).

Experience of both sexual and physical abuse has been reported as a major characteristic of women in treatment (Boyd, 1993). It is estimated that between 36% and 75% have a history of childhood sexual,

physical, or emotional abuse (Boyd, 1993; Roesler & Dafler, 1993; Wilsnack, Vogeltanz, Klassen, & Harris, 1997).

Many women in treatment are pregnant or parenting and this has ramifications not only for the women, but also for their children and families (Stevens & Arbiter, 1995). Familial patterns of substance abuse (Merilangas & Stevens, 1998) have been identified in a number of studies. Environmental influences on substance use have been identified, including the effects of intergenerational substance use—which may encompass mother, father, siblings, and grandparents—peer influences, and age of onset. A history of dysfunction in the family of origin often affects the mothers' actions and relationships with their own nuclear families (Harmer, Sanderson, & Mertin, 1999). In addition to studies that have identified environmental influences, increasing evidence in the alcohol studies literature suggests a genetic predisposition to alcoholism in certain families (Sher, Gershuny, Peterson, & Raskin, 1997). Given the multifactorial influences on substance abuse, treatment must be multidimensional. The inclusion of parenting and family issues provides a holistic treatment approach that addresses the multiple needs of substance-abusing women (Camp & Finkelstein, 1997).

Gender-Specific Substance Abuse Treatment Programming

A continuum of treatment models has been developed to address the needs of women in the United States (Table 1), including short- and long-term treatment, outpatient and residential programs, and drug-specific interventions. However, it should be noted that, although the number of programs treating women has increased in the past few decades, there are still not enough programs to meet the identified needs.

Gender-specific treatment programs incorporate relationship issues as a fundamental part of recovery. Treatment programs that address the diverse needs of the substance-abusing population may have a variety of components, including those listed in Table 2.

Table 1
TREATMENT MODELS

- Pretreatment
- Detoxification programs
- Outpatient methadone maintenance programs
- Outpatient treatment
- Residential or domiciliary treatment
- Self-help and support groups

In a review of the literature, Howell, Heiser, and Harrington (1999) report that gender-specific, family-focused, and culturally sensitive programming, provided by multidisciplinary, relationship-oriented staff, are important components of successful programming for women. **Gender-specific treatment shifted from a male approach, which is authoritarian and confrontational, to an approach using the relational model. Acknowledging the integral part that relationships play in the psychological development of women and the need for empathic approaches has led to fundamental gender-specific programming changes** (Finkelstein, 1994; Gillian, 1982). The relational model uses the "self-in-relation" theory (Jordon, Kaplan, Miller, Stiver, & Surrey, 1991), which places the emphasis on psychological development through connection with others. Women bring to treatment many issues that are fundamental to the relational model. They include women in relationships (as daughters, partners, and parents) and in relation to violence that has been a central part of their lives (Finkelstein, 1994). As programs for women were implemented, specific needs became apparent. **Primary among them were the practical needs of women with children.** Many women were unable to access treatment without provisions for their children. At first, this generally meant childcare. However, as the

Table 2
TREATMENT COMPONENTS

- Assessment and diagnosis
- Chemical substitution (i.e., methadone)
- Substance abuse therapy
- Group therapy
- Individual therapy
- Alternative medicine including acupuncture
- Health care
- Family services
- Parenting programs
- Case management
- Infant mental health services
- Educational, vocational, and life skills training

effects of drug abuse on the family became more widely recognized (Zuckerman, 1994), some programs began shifting to an ecological, family-focused treatment approach (Horn, 1994). **These programs provide prevention and treatment services for the children, as well as for the parents** (Brindis, Clayson, & Berkowitz, 1997).

Group Therapy

Therapeutic interventions used in gender-specific drug treatment are increasingly documented in the literature. These include psychotherapy and cognitive, family, and infant mental health therapies, as well as relapse prevention and behavior change techniques (Moras, 1998). However, rigorous scientific studies on effective treatment methodologies are scarce. This can be attributed to the difficulty of implementing applied research procedures in treatment settings with a substance-abusing population and to the newness of the treatment focus on women and their children (Onken & Blaine, 1990).

Until the advent of gender-specific treatment, the normative treatment approach was to establish sobriety before beginning to treat psychodynamic issues. The clinical literature increasingly suggests that this approach may not be the most appropriate for women's treatment and that addressing psychological issues should come sooner (Root, 1989). **While individual therapy approaches may be a fundamental part of treatment, the value of incorporating a group therapy approach is increasingly apparent.**

Group therapy has been identified as particularly suited to meet the complex needs of women in recovery. This approach is designed to increase knowledge of self and understanding of the other participants in a safe, accepting, and trusting environment (Corey & Corey, 1992). The described group approach presented didactic education within a psychotherapeutic context. The women were presented with new concepts and new language within a structure that enabled them to immediately begin to use and practice what they had learned. The language and concepts were designed to help participants identify their feelings and to use them to express themselves. The group context provided them not only with a safe place, but with peers who were able to share their common experiences. Learning that others have experienced similar situations validates the participants' sense of reality and lessens their feelings of loneliness.

Loss and Grief Group Therapy

Loss is a theme commonly identified in the lives of many substance-abusing women. Further clinical assessment often reveals unresolved grief (Raskin, 1992). Broadly defined, loss may include traumatic or dysfunctional events, as well as separation or death (Bollerud, 1990; Edelman, 1994). Unresolved issues of loss and grief can have negative outcomes. However, it is not clear whether the problematic outcomes are predominantly associated with the loss or trauma, or with the lack of resolution of the issues (Browne, 1993). Among the identified sequelae are depression (Boyd, 1993; McCauley, Kern, Kolodner, et al., 1997); post-traumatic stress disorder (Bollerud, 1990), drug or alcohol abuse (McCauley, Kern, Kolodner, et al., 1997), low self-esteem (Chiavaroli, 1992; Metsch, Rivers, Miller, et al., 1995), and difficulty establishing healthy relationships with significant others and with their children (Edelman, 1994).

Unresolved loss and grief issues are associated with drug use and can inhibit or prevent recovery (Beechem, Prewitt, & Scholar, 1996; Denny & Lee, 1994). Group therapy, focusing on loss and grief, has been identified as a valuable treatment approach providing the opportunity for women to explore common experiences in a supportive environment (Kauffman, Dore, & Nelson-Zlupko, 1995; Luthar & Walsh, 1995).

Studies on substance abuse treatment for women indicate that those who stay in treatment longer have better treatment outcomes (Stevens & Arbiter, 1995; Coletti, Hughes, Landress, et al., 1992; Hughes & Fox, 1993). In one study of a loss and grief group (McComish, Greenberg, Kent-Bryant, et al., 1999), it was found that women who participated in the group remained in treatment significantly longer than women who did not participate. **This suggests that participation in the loss and grief group influenced their retention in treatment, potentially enhancing treatment effectiveness,** in addition to any specific benefits that may have been derived from participation in the group.

The treatment program provided a mulitfaceted intake assessment protocol with treatment reviews every three months. At intake, the women were given a battery of biopsychosocial assessments, which included the Substance Abuse Subtle Screening Inventory (SASSI; Miller, 1985) and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2; Butcher, 1989), as well as a psychosocial history interview. In addition, for both clinical and program evaluation purposes, the women were assessed with The Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977), the Hudson Index of Self Esteem (ISE; Abell, Jones, & Hudson, 1984), and the Profile of Moods States (POMS; McNair, Lorr, & Droppleman, 1981). Parenting attitudes were assessed using the Adult Adolescent Parenting Index (AAPI; Bavolek, 1984)). These instruments, and others for the children, were given over a two-week intake period by a multidisciplinary team, which included a clinical psychologist, substance abuse counselors, infant mental health specialists, speech and physical therapists, and an educational psychologist. At the end of the intake period, the multidisciplinary team met and developed an initial treatment plan based upon clinical observation, client input, and findings from the assessments. The treatment plan was then implemented and reviewed quarterly.

The loss and grief group was initiated by the infant mental health therapist. She had observed the themes of loss and grief in her sessions and in sessions with other counselors. An overwhelming number of women identified personal traumatic losses in their therapeutic work. It was felt that developing one group that focused directly on these issues would address treatment needs not covered in other treatment components.

The objectives of the group were to (1) give didactic information on the nature and stages of grief, (2) help each woman to identify her sources of grief, and (3) to provide a safe, supportive place for each woman to tell her story using her new knowledge and language. **A key treatment component was the connection made by many of the women between their earlier losses, loss/separation with their children, and the ways their substance use and relapses were related to lack of resolution of their loss/grief issues.** For example, some women noticed that they experienced a relapse on the anniversary date of a significant loss.

The six-week format included both didactic information on the stages of loss and grief and traditional group psychotherapy. In addition to interpersonal interactions, the group structure included individual writing and reading, and personal written or artistic creations. Individual therapeutic sessions were used to augment group treatment as needed. The sessions had an identified focus. In session one, the overall structure was explained, group norms were developed, and story sharing within a safe environment was modeled. In session two, the emphasis was on acquiring didactic information about loss and grief, including Kubler Ross's (1969) stages of grief as related to their personal feelings. Sessions three and four consisted of sharing stories using the knowledge of loss and grief and the language that had previously been introduced. Session five introduced strategies for coping with the grief and loss, and their relationship with substance use. In the final session, the women used their new coping strategies to put closure to the group. At the end of each session, every woman filled out a personal response sheet.

The following case study combines the stories of a number of participants to protect confidentiality. The case follows Katrina through a six-week program, highlighting the program structure and her own insights and development.

Case Study:

This case study describes a loss and grief group implemented at a residential substance abuse treatment program. The grief group met 90 minutes each week for six weeks. This was a voluntary closed group.

Katrina is a 23-year-old African-American single mother of Daniel, 6, and Carmaine, 2. She began using cannabis, at age 13, under her older sister's influence, and shortly after began drinking alcohol. When she was 15 years old, she began using crack cocaine, and her addiction level steadily increased until she entered treatment.

Katrina dropped out of high school in the 10th grade and gave birth at age 17. She entered the protective service system with a charge of child neglect due to drug use. She was unsuccessful in

outpatient treatment, and her children were placed in foster care. Residential treatment was ordered as a condition of reunification. At treatment entry, Katrina was diagnosed with poly-substance dependence and histrionic personality disorder. Initially, Katrina had a difficult time with the program structure. After 9 months in treatment, she was reunified with her children. A month later she began the grief group.

At the individual presession meeting with the infant mental health specialist, Katrina immediately identified two losses: the separation from her children and her uncle's death. She had been raised without a father and her uncle had assumed this role.

Session One:

At the first session, Katrina tearfully shared the experience of the protective service worker physically removing her children from her for foster placement. She also talked about not receiving emotional support as a child. She had not viewed this as a loss until others in the group discussed it in those terms. Finally, she mentioned the death of her uncle. At the end of the session Katrina indicated that she was relieved to be expressing these painful feelings.

Session Two:

As the sessions continued, Katrina used the Kubler-Ross (1969) stages of loss and grief to identify her use of denial. She shared the loss of her children and uncle, and admitted that she generally dealt with loss issues by using denial. Katrina related that she refused to think about her uncle when he died, and refused to think about her children when they went into foster care because it was too painful. Katrina reflected that during each of these incidents, she increased her drug use. She now understood that it was to repress her awareness of what was happening.

Session Three:

Katrina attended the third session, but did not talk. However, she indicated on her response sheet that she had been tearful while others were telling their stories because she could relate to them. She began to realize that she was no longer alone and that the other members could help her through the grief process. She said that she was afraid to grieve.

Session Four:

During the fourth session, Katrina told in detail how she lost custody of her children. They were removed as a result of a drug raid in which she went to jail. At that time, her children went to court-ordered kinship care. When she was released from jail, Katrina picked up her children and went "on the run" with them. A family member convinced her to turn herself in, and she lost them for a second time when they were physically removed from her. Katrina admitted that this group had aroused strong emotions and she remained tearful throughout the session. Katrina brought up that she was having a difficult time in treatment and contemplated leaving. The group questioned her about denial regarding the loss of her children if she left treatment and asked if she was ready to endure another separation from them. She indicated that she would do whatever was necessary to remain with her children.

Session Five:

The fifth session was spent exploring anniversary reactions and how to positively commemorate losses. Katrina actively participated in this session. She talked about her new understanding of grief. She identified how she used a "happy face" to deny the losses she had experienced throughout her lifetime. Aware of her use of denial, she began to question other life experiences, for example, "Why did my mother leave me when I was a teen?" In her response sheet, Katrina indicated that she valued the loss and grief group and was sad to see it end. The group had enabled her to identify her denial and begin to explore the many areas of loss and grief in her life.

Session Six:

In the last session, Katrina commemorated her loss by writing a letter to her children. First, she apologized for their foster care placement. She acknowledged that it was a painful time for all of them. She further explained that the lifestyle she had led during their separation

would not have been safe for them. She admitted that she had not been a good parent and said that this was a painful truth. Katrina told her children that she wanted their childhood memories to be happy, secure, and full of love. Finally, she let them know that the separation was not their fault, that she loves them and will continue to work on being the parent they deserve. Katrina shared that this group has allowed her to face her grief and that she understands that grieving is an ongoing process. Katrina indicated that she felt supported by the group and learned to gain support from a group.

Conclusion

Substance abuse is a national health and mental health care concern, and the need to identify effective interventions is paramount. The advent of gender-specific substance abuse treatment in the 1970s not only changed theoretical and philosophical approaches to treatment, but also contributed to a new paradigm in treatment approaches that evolve in response to client needs. The relational model has guided the implementation of programming that addresses the needs of women. Studies that demonstrate the effectiveness of this paradigm shift are increasing (McComish, Greenberg, Kent-Bryant, et al., 1999; Fiorentine, Nakashima, & Anglin, 1999).

The identification of critical clinical issues for women that are related to their substance abuse is fundamental to addressing client needs. Gender-specific treatment has increasingly combined these issues with appropriate treatment modalities. Group therapy is one treatment component which is proving effective. Research indicates that factors inherent in this treatment modality itself may facilitate healing. These factors include learning that others have experienced similar traumas, receiving advice, modeling successful behaviors of others, having a sense of belonging, and gaining self-understanding and hopefulness (Yalom, 1985).

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

9. Which one of the following statements is correct?

A. The field of substance abuse treatment previously focused almost exclusively on women and not men.

B. Women who abuse substances often exhibit fewer health needs than women in the general population.

C. Women who abuse substances appear to be predisposed to more medical problems than male substance abusers.

D. Women who enter treatment do not usually have any incidence of previous sexual or physical abuse.

10. Gender-specific treatment programming:

A. Is based upon the traditional male treatment model.

B. Does not incorporate prevention and treatment services for children.

C. Incorporates the relational model in treatment approaches.

D. Focuses on substance use issues only.

11. The treatment components for women in substance abuse treatment should:

A. Focus solely on substance use.

B. Have an authoritarian, confrontational underpinning.

C. Not include treatment for their children.

D. Approach treatment from a multidisciplinary, multidimensional perspective.

12. The use of group therapy in gender-specific substance abuse treatment:

A. Has proven to be fundamental when incorporated into the individual therapy approach.

B. Was found to influence the retention of participants in treatment, thus potentially enhancing treatment effectiveness.

C. Is particularly suited to meet the complex needs of women in recovery.

D. All of the above

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DIRECTIONS
Volume 11 Lesson 4

Family Therapy with Lesbians and Gay Men

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Introduction

Family therapy, or systemic therapy as it is often called (this admits the possibility of working with couples or individuals in a systemic way), **has, as one of its most basic concepts, the need to see clients in the light of their "context."This context includes, of course, their significant relationships or "systems"— familial, peer, and social — and the larger cultural and social context in which the clients reside.** The thinking behind this is that people and their feelings are not "decontextualized,"but operate within a context, which helps to determine their beliefs, assumptions, and activities. Consequently, for any client group, such as lesbians and gay men, their feelings about themselves and the world cannot be divorced from the world's feelings about them. In other words, all family or systemic therapy must consider that many lesbian and gay clients will have had the experience of feeling adversely judged, or considered "ill"or "unnatural."At some level this will affect their feelings about themselves, their significant relationships, and their response to the world outside. Also, they may initially feel the need to defend themselves against an unexpected or feared negative reaction from their therapist (Malley & Tasker, 1999).

It is important to remember that lesbians and gay men do not form a homogenous group and that they represent a wide spectrum of humanity in terms of race, culture, nationality, age, religion, political affiliation, ability, and every other possible variable; they may identify much more as an older person, or a Hispanic person, than as a gay man who is older, or a lesbian who is Hispanic. Identification as a lesbian or a gay man may not have been a life-long state—many lesbians and gay men also have had heterosexual relationships or been married, before or sometimes after choosing to identify as lesbian or gay (Bell & Weinberg, 1978). **It may be more realistic to regard sexuality, or sexual orientation, as a continuum along which people place themselves, rather than as a rigidly fixed or biologically or genetically determined state** (Davies & Neal, 1996). Unlike many other minority groups, whose minority status may be visible, audible, or apparent in another way, lesbianism or gayness is not visible, contrary to societal myth (Warren, 1980). There is, however, heterosexism (a "heterosexual assumption"in our

society) that presumes heterosexuality unless otherwise stated, and it is this that requires mental health professionals to consider issues of nonheterosexual sexuality as a backdrop to all their work, not just when there is a named issue of lesbianism or gayness.

By incorporating such an awareness into our practice, we are well placed to be of positive assistance not just to clients who are "out"— in other words, openly self-identified as lesbian or gay in significant contexts of their lives — but also to those clients who may be currently struggling with these issues themselves, or those who may react negatively to a significant other who is moving toward an identification as lesbian or gay. Reflecting dominant cultural values, such an identification may be seen as shameful or as reflecting some deficit in upbringing, significant relationships, or some kind of moral or "organic"flaw (Krajeski, 1986), and so it may remain a traumatic secret for families, couples, or individuals. It is not uncommon to see families coming into family therapy to try to resolve the issues raised by a family member's "coming out,"which has sparked off a whole cycle of denunciation, self-blame, split loyalties, and ostracism (Simon, 1996 ; Woodman & Lenna, 1980; Bernstein, 1990; Neisen, 1987; Strommen, 1989). **Equally, family and systemic therapists see clients all the time who are struggling with these issues but who do not feel safe enough within the therapeutic context to risk disclosing their identification, their dilemmas, or their feelings** (DiPlacido, 1998).

There are two main topics for mental health professionals to consider in this area. First, clinicians need to consider whether lesbian and gay-affirmative family or systemic therapy practice is possible. Second, mental health professionals need to consider the central issues or circumstances that may be specific to working with this client group.

Is Lesbian and Gay-Affirmative Family Therapy Possible?

In the past 20 years there has been an increasing acceptance that the **therapeutic setting is not a neutral or objective one, and an acknowledgment that much counseling, psychology, psychiatry, and psychotherapy theory and training incorporates negative or homophobic attitudes** (Iasenza, 1989; Clark, 1987; Shelley, 1998). There is also an increasing awareness that our **therapeutic assumptions are often based around the norms of the "dominant"culture**; therefore, **we may need to adapt our theory and our practice when we work with clients who are not white, male, and heterosexual.** Within systemic theory, there has been emphasis given to gender and ethnicity as centrally defining experience in life and in therapy, but less attention has been given to lesbian and gay male sexuality as equally central. This may be because of the less visible nature of sexuality as a variable or because of prevailing negative judgments directed at lesbians and gay men (Clark & Serovich, 1997). Whatever the cause, the issue for mental health professionals is to consider how their practice needs to adapt to encompass this population.

The idea of "retraining"(Clark, 1987) has been used to describe the work that mental health professionals need to engage in to explore their own personal and professional attitudes toward homosexuality and the possibly heterosexist and homophobic assumptions that may underlie these attitudes. The emphasis is on rethinking of practice and the ideas on which it is based, rather than merely assuming that one therapy fits all. Table 1 lists many of the central issues and key aspects for therapists to consider in relation to lesbian, bisexual, and gay identity formation and sustainability

These are the first steps in any affirmative approach, particularly when combined with an awareness that **for most lesbians and gay men possible negative responses from their family of origin and earlier peer groups may have led to an internalized homophobia or lack of self-esteem, which they may carry into their relationships and their family of choice (significant others who are not biologically related). This internalized homophobia may also be reflected in the therapeutic encounter:** Stanley Siegal and Gillian Walker (1996) give a useful example of the latter point when they discuss the situation of lesbian or gay clients who want to see a heterosexual therapist solely because they feel that heterosexual therapists must necessarily be better or more influential in some way. While there may be a host of perfectly valid reasons why anyone might want to see a therapist who is different from them in some way, this is distinct from the belief that such a therapist must be better because

Table 1

CENTRAL ISSUES AND KEY ASPECTS FOR THERAPISTS TO CONSIDER IN RELATION TO LESBIAN, BISEXUAL AND GAY IDENTITY FORMATION AND SUSTAINABILITY

Central Issue	Aspects to Consider
Possible templates for relationships	Roles within relationship Need to accommodate change over time The applicability of family life cycle models
Families	Families of origin Families of choice Children
Level of integration within the mainstream	Levels of "outness" (internal and external) Depends on contexts Depends on other identities

they have an attribute more valued in this culture—heterosexuality in this case.

Relationship Templates:

In an intimate relationship, models or templates may provide both a useful guide summarizing the relationship and suggest ways of channeling future aspirations and expectations. These guidelines for relating also provide a rule of thumb for how the couple interacts with others outside the relationship and suggests to others how the couple wishes to be viewed. However, templates also restrict other viable possibilities. Over time, a once useful template may serve to fossilize the relationship, cutting off new ideas that may have blossomed into growth.

Templates of heterosexual relationships are readily observed within the family, neighborhood, and society and are familiar to the couple and fit within these contexts easily. **While it is recognized that heterosexual templates will constrain the couple in some way, there is often some choice. Family therapy has a long tradition of using templates from family life cycle models to contextualize the difficulties the family brings to therapy** (see Carter and McGoldrick's [1999] newly revised and extended family life cycle model). Indeed, exploring current difficulties within a family life cycle model can help locate difficulties at points of transition and can help the family progress beyond them.

It can be difficult to be constantly aware that some of our core therapeutic models may be heterosexist or irrelevant to a lesbian or gay male population. **Templates for heterosexual relationships do not easily fit lesbian or gay relationships as guidelines for heterosexual relationships are not equipped to deal with how to protect a same-gender relationship from the stigma and discrimination attached to homophobia. Furthermore, templates for heterosexual relationships are often based on gender roles.** While some same-gender relationships may develop like this, most do not. Various community surveys have suggested that same-gender relationships tend to be based on a more egalitarian division of labor and that domestic tasks are divided on ability and interest rather than on gendered lines (Dunne, 1998; Kurdek, 1995). **Another example of the inappropriateness of heterosexual relationship templates to lesbian or gay couples is in the idea of "optimum distance"(emotional and psychic) within relationships. Lesbian relationships have often been characterized within systemic therapy as "overclose"or "fused"whereas gay male relationships are judged to be distant or detached** (Goodrich, Rampage, Ellman, & Halstead, 1988; Krestan & Bepko, 1980; Klinger, 1996). This was not a judgment arrived at from studies of problems within lesbian and gay relationships, but from a comparison with the concept of distance in heterosexual relationships, yet was accepted by many systemic therapists. Patterns of emotional intimacy in terms of closeness and privacy desired by same-gender couples may not fit heterosexual expectations (Green, Bettinger, & Zacks, 1996; Hill, 1999).

Within the lesbian and gay community, a wide variety of relationship patterns may be observed and appropriated by the couple for their own relationship

(Kitzinger & Coyle, 1995). However, accessing these patterns is often a challenge because many couples are isolated from their communities partly because of the invisibility of their identity. Furthermore, the most visible lesbian and gay scenes are inhabited by the young and out, and those with longstanding relationships or parenting responsibilities tend to be less noticeable. **Because of heterosexism and homophobia, patterns of relationships that fit within lesbian and gay cultures may not integrate well with other aspects of life that have to be lived within mainstream society.** Consequently, lesbians and gay men, and particularly bisexual women and men, face the challenge of integrating multiple identities and managing competing demands. Templates or roles within the relationship will also need to accommodate change and unanticipated external events.

It may be useful to consider the models of the lesbian or gay family life cycle that have been proposed. Slater (1995) suggests a five-stage model of the family life cycle for lesbian couples based on developmental changes in the features of the couple's relationship. The model is not centered on reproductive events, although it can incorporate the transition to parenting if that is appropriate for the couple. The model begins with the formation of the couple's relationship, focusing on the excitement and vulnerability that both parties feel at this time. Stage two involves how the couple set up their relationship and explore the emerging similarities and differences. Stage three puts commitment on the agenda as the couple decides whether to make the relationship part of their future priorities. This brings the advantages of increased trust and security in the relationship, but each partner has to be content with sacrificing other possibilities. The need of the couple to make an enduring contribution either through working on joint projects and/or through sharing in parenthood summarizes the fourth stage of Slater's life cycle model. The final stage in the model deals with the issues faced by older couples, in which the couple contends with life changes imposed by retirement, the possibility of grandparenthood, illness, and ultimately the death of one partner. Prior to Slater's model, McWhirter and Mattison (1984) proposed a family life cycle model of the gay male relationship, outlining six stages in the couple relationship: blending, nesting, maintaining, building, releasing, and renewing. Stages one to four are more or less compatible with Slater's early stages. However, McWhirter and Mattison include the extra stage of "releasing"in their model, suggesting that once the relationship is established, the partners within their relationship resume work on their own identity projects before renewing the relationship.

These models of the lesbian and gay family life cycle may be useful for therapists because they emphasize many important issues faced by same-gender couples. There are, however, many difficulties in articulating a prototypical family life cycle for lesbian and gay couples, and though many of these are accepted in the models outlined above, they indicate that these models should not be applied as prescriptions for couple and family therapy. **In many cases it may be more appropriate to focus on processes within the relationship, such as patterns of conflict, dependence, and individuation, rather than attempt to fit these within a family life cycle model** (Malley & Tasker, 1999).

Families:

Couple relationships exist within a wider network of relationships. The family relationship system sustains and constrains the connection between the couple, not only providing emotional and practical support, but also setting the rules for when the relationship is recognized or not. In many families, not all members of the system will share the same sexuality (Demo & Allen, 1996). For example, the majority of children raised in families led by a lesbian or gay parent develop heterosexual identities (Bailey & Dawood, 1998) just as the majority of lesbian and gay adults have heterosexual parents. However, all family members will need to accommodate the sexual identity of other family members. **Like lesbian, bisexual, and gay family members, heterosexual family members will need to develop a strategy for dealing with homophobia, which may be encountered by the family just as much as the lesbian, gay, or bisexual family member.**

The idea of widening the definition of family (and therefore of family therapy) is an important one. The use of terms such as "family of origin" (the family into which we were born or raised, and which may be a family of biological, foster, or adopted parents or caregivers) and "family of choice"(the chosen family of les-

bians and gay men, which may be composed of friends, ex-lovers, lovers, their children or those they co-parent, biological family members, or family members of lovers or friends) seeks to differentiate between the actual, rather than the presumed, relationship constellations of our lesbian or gay clients. **To assume that family only includes members related by blood or marriage, excludes many lesbian and gay clients and many heterosexual clients increasingly living within non-nuclear family structures, as does the presumption that "ideal" partner or lover relationships are long-term, ongoing and monogamous.**

Since there are no societal models for types of lesbian and gay parenting, lesbian and gay parents have to develop their own strategies. Often their experiences within their own heterosexual families of origin may not directly translate to parenting in a lesbian or gay family context. This can, of course, be a liberating experience in terms of the opportunity to devise new rules, but it can also make parents feel anxious and unsupported. Many who come into therapy may feel closely scrutinized to see if they are good enough parents (McLeod & Crawford, 1998). Studies indicate that children brought up in lesbian households are at least as well-adjusted psychologically as children from heterosexual families (Chan, Raboy, & Patterson, 1998; Tasker & Golombok, 1997), but this does not prevent societal disapproval or scrutiny still being evident (Hargaden & Llewellin, 1996).

The dilemmas that bring "reconstituted families" into family therapy often include a need for renegotiation about responsibilities for the children and differences in parenting styles. However, research has shown that stepfamily relationships in post-divorce households led by a lesbian mother and her female partner can work very well (Tasker & Golombok, 1997). In households where a lesbian couple has planned to have a child together, there tends to be more sharing of childcare responsibilities among biological and nonbiological parents than in heterosexual families (Tasker & Golombok, 1998) and often greater parenting satisfaction and less couple conflict as a result of this greater equality (Patterson, 1998). **Negotiations around issues such as finance or division of tasks may result in a more equal division of resources in lesbian relationships, though against this must be set the problems that may arise from the socialized tendency of women to be better caregivers than care receivers, and the difficulty women have stating their needs in relationships, rather than fulfilling the needs of others** (Slater, 1995).

Levels of Integration

There are concrete differences in the context in which lesbians and gay men live their lives and constraints to integration that are not faced by heterosexuals. External constraints on the level of outness may be embodied in the legal system—restrictions on the right to inherit property or tenancies; pension rights of partners; barriers to immigration or residence; lack of employment protection; not being recognized as next of kin in terms of medical emergencies, in the care of jointly parented children, or in terms of retaining custody of children. These constraints also vary from country to country and state to state. The discrimination may not be enshrined in law, but may be equally pervasive, for example, the reaction when booking double rooms in hotels, the response when putting a same-gender name under "Next of Kin" on a personnel form at work or at college, the feelings of anxiety when holding hands on the street with your lover or taking your lover to work or social events as your partner; there are few aspects of life that go unaffected.

These are restrictions or causes of concern for all lesbians and gay men. They pervade not just the day-to-day circumstances of life, but also the sense of comfort or discomfort, safety or vulnerability, in the worlds of work, leisure, and social, emotional, and sexual relationships. Legal barriers to the equal rights of lesbians and gay men are being increasingly challenged, but this does not seem to render this population any less vulnerable to homophobic hate crimes (Franklin, 1998; Herek, 1991), in which people who are perceived as lesbian or gay are attacked simply for that reason. Indeed, such attacks seem to be increasing, possibly because of the greater visibility of lesbians and gay men in society (Berril, 1990). However, the majority of attacks may go unreported (Klinger & Stein, 1996), possibly because of concerns that the report will not be taken seriously and because of fear of reprisals.

The level of integration within mainstream heterosexual society depends first and foremost on the

ability to evaluate particular contexts. Few contexts are value free, and a key skill for lesbians and gay men to develop is the ability to judge when it is safe to reveal and how much. Choices about where and how people choose to be out are highly individual; some may choose to be out within their social and familial circles, but not in a work or other "outside"world setting. Some choose to be out in all settings, other than with their biological family, and some choose to be out only with lesbian and gay friends. There are endless permutations, though the decision to be out or not out in a particular context is often connected to the anticipated reaction, or consequences—the fear of losing employment or being ostracized by friends and family. These fears or internal constraints may be entirely realistic and well-judged, or the actual response may be much more benign than anticipated; unfortunately, this is difficult to predict accurately. How safe it is to be out in a particular context will also depend on how this can be handled in relation to the other identities the person has, such as the gender roles the person perceives as appropriate for them as a woman or a man and their self-concept of motherhood or fatherhood. One important aspect in this equation is the variation in cultural views on lesbian and gay relationships held by different ethnic groups (Greene, 1994; Morales, 1996; Newman & Muzzonigro, 1993). **Different cultural values may create a more or less supportive context for lesbian and gay relationship visibility and different possibilities for the integration of multiple identities within the self-concept.**

Case Example:

Sharon and Elizabeth are a couple in their 30s; they identify as black English women, who both have children from previous relationships. Sharon has one daughter, aged 12, and Elizabeth has twin sons, aged 5. They have been lovers for almost 2 years and are contemplating moving in together. Elizabeth was previously married and is currently divorcing her husband; she has some apprehension about his reaction, should she and Sharon live together.

They have come to family therapy to talk about the issues arising from their different styles of parenting, whether they should try to co-parent all the children, not just their own, in terms of sharing equal responsibility for support and discipline. They also want to discuss their different levels of outness and how this affects their lives and their children. One particular dilemma for Sharon and Elizabeth is that they are not equally out. Sharon is out in all contexts, including at her daughter's school and with both sets of grandparents. Elizabeth feels much more apprehensive about the consequences for her sons if she is out at their school. More specifically, she is ambivalent about whether she wants Sharon to come to parent–teacher evenings at the school and whether the boys could have friends at the house if she and Sharon decide to live together. While Sharon sympathizes with Elizabeth's apprehension, she thinks that Elizabeth's feelings have at least as much to do with internalized homophobia, as with the kind of genuine dilemmas that Sharon also had to face when her daughter was growing up. Sharon finds it hard not to feel rejected when it appears that Elizabeth wants their relationship to be invisible in some contexts.

Issues for the Therapist to Consider

Since there are no societal models for lesbian parenting (i.e., no way for Sharon or Elizabeth to recycle the knowledge gained from their heterosexual mothers' parenting of them), they will have to develop their own strategies. On the horizon are the difficulties that might be raised by Elizabeth's ex-husband's disapproval of the couple's living arrangements and the potential threat of him seeking to get custody of the twins on the basis that Elizabeth is an unfit mother by reason of her lesbian relationship. It is not unusual for lesbian mothers to avoid sources of conflict, such as issues of financial support or access, because they are scared this may provoke a custody battle (Hargaden & Llewellin, 1996).

If they decided to move in together, Elizabeth and Sharon and their children will confront issues that other stepfamilies face around the negotiation of responsibility for children and possible clashes of parenting styles. But they also face the added challenge of fear of homophobia. This can effectively "silence"a lesbian partnership and prevent acknowledgment by the children and others of the couple's relationship and their parenting of each other's children.

It may be useful for Elizabeth to hear that there is research that indicates that children of lesbian mothers (whose sexuality is known about by the children's peers) are not less popular among their peers because of this (Green, Mandel, Hotvedt, Gray, & Smith, 1986), though adolescents may feel that they are more likely to be the target of harassment from peers around this issue (Cramer, 1986). Conversely, it may be much more useful for the therapist to simply let Elizabeth explore her own anxiety and ambivalence; she may be at a different stage than Sharon in terms of grappling with feelings of internalized homophobia or comfort with being able to be open about her sexuality and the relationship. Since this is an issue that all lesbians and gay men have to wrestle with, Sharon may find it easier to accept and sympathize with these feelings once she is reassured that Elizabeth does not feel doubtful about the relationship per se and may be much more willing to negotiate separate or differing degrees of outness in different contexts.

Conclusion

Therapists should always remember that **issues of visibility and validity will often be present when talking about relationships or family dilemmas with lesbian and gay clients. They may have had few opportunities to tell the story of their relationships and this in itself may be an important therapeutic task—to let clients review and recapture the history of how the relationships or families came to be, rather than an immediate concentration on the current problems.** It will always be important to look at the context in which the relationship or family exists: how it is supported or reinforced and how it may be invisible or undermined. **For many lesbian and gay relationships or families, the ratio of support to invisibility or active denigration is not equal, and one of the therapist's tasks may be to help clients redress this balance.**

Clinical judgments derived from the systemic norms of heterosexual relationships cannot be assumed to transfer to lesbian or gay male relationships (Burstow, 1992; Walker & Goldner, 1995); this does a disservice to both populations. Each case involving lesbian, bisexual, or gay clients will raise unique issues, as unique (and possibly less familiar) as each case involving family or systemic therapy within a heterosexual context. There is no universal prescription for therapy. The key to therapy is to acknowledge the difficulties this client group faces and to recognize that these occur within a nonneutral context.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

13. Will all lesbian and gay men come from similar ethnic, economic, class and cultural groups?

A. Yes, they will primarily come from similar groups.

B. No, gay men will tend to be white, and middle-class or wealthy whereas lesbians will be more representative of the population generally.

C. No, they will be as representative of the whole society as any other cross-section of the population, although many may experience discrimination and be less visible.

D. Yes, they will come primarily from poor, single-parent, working class backgrounds.

14. Is it true that lesbians and gay men have problems in their lives because of integral emotional instability?

A No, they have exactly the same problems, of the same types, as anyone else.

B. No, they have the same problems as anyone else, but they also have particular problems in terms of dealing with negative reactions to their sexuality and their own internalized homophobia.

C. Yes, they have more problems than heterosexuals becuase they don't have ongoing relationships or other support in their lives.

D. Yes, they have more problems than other people because of integral instability.

15. Can systemic ideas apply equally to all family populations?

A. Yes, it is patronizing to assume that this population is so different.

B. No, since lesbians and gay men do not have families the whole question is irrelevent.

C. They can apply in working with lesbian and gay male couples, but are irrelevant with individuals as its impossible to use systemic ideas with individals.

D. Yes, provided that therapists are aware that some systemic ideas are based on models derived fromheterosexual populations and therefore may not be appropriate. Lesbian and gay affirmative systemic ideas are illuminating in work with lesbian and gay men as individuals and with their partners.

16. According to the lesson, do lesbians and gay men have problems with parenting?

A. Lesbians have no problems with parenting, but gay men have great difficulty in forming good relationships with children.

B. The problems that they have with parenting are the same as the problems that heterosexuals will have.

C. While children of lesbians and gay men are no more developmentally disadvantaged than children of heterosexuals, lesbian and gay parents may have specific problems because they lack good lesbian or gay parenting role models and may face negative reactions to their identities as parents.

D. They will have major problems becuase their children need heterosexual role models.

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DIRECTIONS
Volume 11 Lesson 5

Psychological and Cognitive Correlates of Coping by Patients with Multiple Sclerosis

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Introduction

In this lesson, you will learn the characteristics of multiple sclerosis (MS), and how it is currently diagnosed and treated by neurologists, the methods used to study coping strategies in patients with MS, and the limitations of these methods, the major psychological, psychosocial, and cognitive correlates of patterns of coping by patients with MS and their caregivers, and techniques for assessing psychological and cognitive characteristics of patients essential to developing successful therapy.

About MS:

MS is a chronic autoimmune disease in which the body's immune system attacks the myelin in the central nervous system, causing inflammation, sclerotic plaques (scars), and eventually neuronal loss. The cause of MS is unknown, and until the introduction of interferon (Betaseron, Avonex) and glatiramer (Copaxone) therapies (often called the ABC drugs) in the 1990s, treatment was entirely palliative. Each of these drugs reduces the frequency of attacks (relapses or exacerbations) and may slow disease progression.

MS is about twice as common in women as in men, and is more common in individuals of Northern European descent than in peoples of other ancestry. There are between 250,000 and 400,000 people with MS in the United

States and Canada (Anderson, Ellenberg, Leventhal, et al., 1992). The highest prevalence rates are found in the populated areas of Canada along the United States border and in the northern US states that are near the Canadian border. The prevalence of MS in the southern United States is much lower, approximately one-third to one-half of the rate in the northern United States and Canada.

The hallmark of MS is its unpredictability. The first attack usually occurs before age 30 (Ebers, 1986), but may occur later in life. The initial symptoms may be predominately sensory (e.g., blurred vision, blindness, tingling sensation in the arms or legs) or motor (e.g., clumsiness, weakness in the upper or lower limbs). After a period of a few days to several weeks, the attack remits spontaneously and neurologic function usually recovers, corticosteroid therapy often speeds this process. Recovery may be complete as in the benign and relapsing-remitting forms of the disease, or quite incomplete, as in the primary and chronic progressive forms in which neurologic impairment, rapidly or slowly, but continuously, increases over time.

A second attack (relapse) may occur weeks, months, or years after the first, or no second attack may ever occur (benign MS). **A pattern of relapse interspersed between periods of remission in which recovery is complete, or nearly so, is the most common disease course. However, a substantial proportion of patients initially diagnosed with relapsing-remitting disease will, eventually, convert to a progressive disease course. Because of the varying disease types, the long-term prospects of serious disability are uncertain.** However, within 15 years of disease onset, about 50% of patients require assistance in walking and 10% are wheelchair bound (Weinshenker, Bass, Rice, et al., 1989).

Stressors and Coping for Individuals with MS

Prior to the wide availability of magnetic resonance imaging (MRI) and drugs that may alter the disease course, most neurologists did not raise the possibility of MS until the patient experienced a second attack. (The clinical diagnosis of MS requires evidence of lesions disseminated in time and space.) With improvements in diagnostics (achieved by increased resolution of MRI scanners), as well as the availability of drugs that reduce the frequency of relapses (which can be frightening to the patient) and may slow deterioration, many neurologists advise treatment with Avonex, Betaseron, or Copaxone as soon as possible. The long-term benefits of this approach cannot yet be judged, but the costs of treatment are high ($10,000–$13,000 per patient year). **Paying for this treatment potentially creates another stressor for patients confronting possible disease-related physical and cognitive impairments, as well as potential loss of employment and disturbances in family and other relationships, in addition to the near certainty of increased medical costs in the long term.** The impact of earlier diagnosis and improved drug therapy on coping is not known.

Facing these challenges, it is not surprising that patients with MS often exhibit considerable psychological distress. Estimates of the point prevalence of depression in MS range from 27% to 54% (Minden & Schiffer, 1990). These findings are consistent with results of a large population study in British Columbia which found a 50.3% lifetime prevalence of major depression in patients with MS (Sadovnick, Remick, Allen, et al., 1996). **Suicide, which can be regarded as the ultimate failure to cope with stress, is elevated in MS, especially in the first five years after diagnosis** (Stenager, Stenager, Koch-Henriksen, et al., 1992; Sadovnick, Remick, Allen, et al., 1991). Rates of divorce are also higher among couples in which one partner has MS (Stenager, Stenager, Knudsen, & Jensen, 1994). **Finally, exposure to stress may trigger the first attack of MS or foster subsequent relapse** (Franklin, Nelson, Heaton, Burks, & Thompson, 1988; Grant, Brown, Harris, et al., 1989), although the existence of a causal relationship between stress and relapse remains controversial (see Warren, 1990).

The elevated rates of depression, divorce, and suicide suggest that patients with MS confront multiple, powerful stressors with which they are unable to cope effectively. This is clearly true for some patients who tend to blame their disease for every disappointment, however slight. Other patients, however, are able to adjust their goals within the limitations imposed by their physical and mental conditions, and remain able to contribute effectively.

In the rest of the lesson we will review how coping has been studied in individuals with chronic disease (not only MS) and describe what variables predict coping patterns by patients with MS. **Like other chronic diseases, living with a person with MS creates additional stress for the spouse and other family members.** For this reason, we also review the limited data on coping strategies used by spouses.

Methods for the Study of Coping: Overview and Critique

Most of the research on coping with stress in chronic disease, including MS, has been guided by the stress-appraisal model of Lazarus and Folkman (1984). **By this account, encounters with stressors (characterized by threat, challenge, or the potential for harm or loss) initiate a conscious cognitive appraisal of the resources available for dealing with the situation. Coping refers to cognitive and behavioral efforts to manage or reduce the distress. Broadly speaking, these efforts may involve problem-focused strategies that are directed outwardly at the source of the stress and emotion-focused coping efforts directed inwardly at managing distressing emotions.**

Studies of coping in patients with MS have most often used cross-sectional designs, and employed the Ways of Coping Questionnaire (WOCQ; Folkman & Lazarus, 1988) or some similar instrument. In a typical study, participants are asked to think of a recent stressful experience, and then complete the WOCQ. This contains 66 statements, each describing a possible coping strategy. Participants indicate on a 4-point scale the extent to which they employ each strategy to cope with the self-selected stressor.

Various factor analyses of WOCQ data have yielded slightly different solutions, but the distinction between problem-focused and emotion-focused coping has emerged consistently. The resulting problem- and emotion-focused coping scores would then be correlated with other information about the participants (e.g., age, degree of disability, severity of depression, cognitive status, etc.). A major virtue of this approach is that it permits rapid data gathering on a large number of subjects, which could, in principle, lead to an accurate description of the many ways patients cope with the stressors they confront. There are also many limitations of the cross-sectional approach in which participants attempt to recollect how they coped with a stressor of their own choice.

The Variability Problem:

Permitting individuals to select their own stressor introduces variability into the data because reasonable ways of dealing with various types of problems (e.g., financial problems vs. falling out of your wheelchair) obviously differ. Standardizing the problem (e.g., Beatty, Hames, Blanco, et al., 1998) runs the risk of selecting a stressor that is not salient for all participants and limits the generality of the findings to the stressors(s) studied.

Asking patients to indicate which strategies they usually use to solve problems (Carver, Scheier, & Weintraub, 1989) risks confusing a stable trans-situational coping style with the respondents' attempts to compute an average of different coping styles across situations. Whether to treat variation in individuals' coping responses as an unwelcome source of noise in the data or as a desirable sign of flexibility in response to differing challenges is an unsolved problem in coping research.

The Validity Problem:

There is usually no operational definition of successful coping. Put in other words, does a particular coping pattern revealed by a questionnaire predict anything about how well patients adapt to situations they encounter in their everyday lives, and is one coping pattern "better" than others? McIvor et al. (1984) **treated level of depression as measured by the Beck Depression Inventory** (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) **as a dependent variable and reported that higher BDI scores (i.e., more depressed) for patients with MS were associated with greater neurologic disability and lower levels of perceived social support from both friends and family.** It is unlikely that depression affected neurologic disability, but high levels of depression certainly could have affected patients' perception of their social support.

Jean et al. (1997) attempted to solve the problem of determining successful coping strategies by having patients rate the effectiveness of their own coping

efforts. **Patients with higher levels of depression and other signs of psychological distress endorsed more emotion-focused items and rated their coping efforts as less efficacious than patients with low levels of distress. It is unfortunately not clear whether psychological distress led to more emotion-focused coping, which was objectively less effective, or simply that the patients' low opinions of their coping attempts were just another manifestation of their psychological distress.** As we consider the psychological and cognitive correlates of coping patterns of MS patients, it is important to remember that they are just that, correlates. The research designs used preclude reaching any stronger conclusion.

An alternative adopted by some researchers, which we do not recommend, is to assume that problem-focused strategies are simply better than emotion-focused solutions. This decision is not supported by any empirical evidence of which we know, and is clearly wrong in some instances. (Formulating a long-range plan is not likely to be of much use if you've just fallen out of your wheelchair and can't get up). Hence, the practice of judging problem-focused strategies as "better" amounts to imposing the researcher's values on the patient.

The Reliability Problem:

Are coping patterns stable over time? This problem has only recently received attention. Packenham (1999) found that patterns of depression and emotion-focused coping by patients were stable over a two-month period and better adjustment (measured by the Psychosocial Adjustment to Illness Scale-Self Report; DeRogatis & Lopez, 1983) was associated with greater reliance on problem-focused coping and less reliance on emotion-focused coping. Aikens et al. (1997) found that life stress and depression were related in a stable fashion over a period of 12 months, but neither problem- nor emotion-focused coping styles exhibited consistent relationships over time. Finally, Barnwell and Kavenaugh (1997) found that self-efficacy was a stable predictor of social activity and mood control over a two-month period for their sample of patients with MS. The available studies are too varied in design to reach a conclusion about this important issue. It may be noted that researchers interested in the relation between coping patterns in persons who abuse alcohol have recently adopted longitudinal designs (Tennen, Affleck, Armeli, & Carney, 2000). These results suggest that the reliability and validity issues raised above may be conquerable.

Comparison of Coping in MS Patients and Other Groups

Comparison of large groups of patients with MS (N=433), or spinal cord injury (N=257), and varying degrees of disability, revealed no significant differences in the frequency of use of emotion- or problem-focused coping (Wineman, Durand, & Steiner, 1994). A smaller study that included patients with brain trauma, spinal cord trauma, or MS who used wheelchairs also found no differences in the frequency of use of these coping styles (Wheeler, Krausher, Cumming et al., 1996).

Jean et al. (1997) **compared coping strategies used by patients with MS and healthy controls. When asked to describe how they coped with general everyday stressors (e.g., money problems, fight with your spouse), there were no significant differences between groups in coping patterns or in self-rated coping efficacy. However, when asked to describe how they dealt with disease-related stressors, the MS patients endorsed more emotion-focused strategies, but there was no loss in rated efficacy of the strategies.**

Thus, there seem to be no important overall differences in the patterns of coping used by patients with MS, controls, or patients with traumatic injury to the brain or spinal cord.

Psychological and Psychosocial Correlates of Coping in MS:

Table 1 summarizes correlational studies which **reported that high levels of emotional distress associated with depression, other psychological disturbance, illness uncertainty, or the occurrence of a disease relapse, were associated with self-reports of greater use of emotion-focused coping.** The consistency of the results is impressive because they appear to generalize samples of patients from clinics throughout the United States and across various measures of distress, including one of obvious ecological validity, a dis-

Table 1

Summary of Studies Reporting a Relationship Between High Levels of Distress and High Levels of Emotion-Focused Coping

Reference	Cause or Measure of Distress
Aiken et al., 1997	BDI, Life Experience Schedule (Saranson et al., 1978)
Arnett et al., in press*	Chicago Mulitscale Depression Inventory, mood scale (Nyenhuis et al., 1998)
Beatty et al., 1998	SCL-90R (Derogatis, 1983)
Jean et al., 1997	SCL-90-R
Mohr et al., 1997	BDI
Packenham, 1999	
O'Brien, 1993	Tennessee Self-Concept Scale Low self-esteem (Fitts et al., 1971)
Warren et al., 1991	Disease Relapse
Wineman et al., 1994	Illness Uncertainty (Mishel & Epstein, 1990)

*The authors distinguish between cognitively effortful and non-effortful coping. Cognitively non-effortful coping is related to emotion-focused coping.

ease relapse. In addition, Buelow (1991) reported a positive correlation between uncertainty about the future and fatalistic coping in a sample of 20 patients with MS. Although there is some overlap between fatalistic and emotion-focused coping, conceptually, fatalistic coping is more closely linked to feeling that one lacks self-efficacy. The association between psychological distress and emotion-focused coping in patients with MS is not surprising; similar findings have been reported repeatedly for other patient groups (Tennen, Affleck, Armeli, & Carney, 2000). Several factors may explain this association. First, patients may have initially tried problem-focused strategies and abandoned them when they failed. Alternatively, problem-focused strategies may never have been employed because they were never considered or because the patient did not believe the stressor could be controlled.

Attempts to discover psychological and psychosocial correlates of problem-focused coping have been less successful. **It might be expected that patients experiencing high levels of distress would make less use of problem-focused strategies. Of the studies listed in Table 1, only four reported evidence of the expected negative correlation.** Mohr et al. (1997) observed that higher BDI scores were associated with less frequent use of problem-focused strategies, but the effect was observed only for patients who could no longer ambulate. Wineman et al. (1994) found that patients who expressed no uncertainty about their illness endorsed significantly more problem-focused coping strategies than patients with low, moderate, or high levels of illness uncertainty. Somewhat more robust effects were described by O'Brien (1993a), who found that patients with high self-esteem reported more problem-focused coping and by Arnett et al. (in press), who found that nondepressed patients with MS used more cognitively effortful responses. Note that cognitively effortful strategies are related to problem-focused strategies, but they are not identical. Several studies have examined the impact of psychosocial factors on patients' overall adjustment to their disease. In general, patients who perceived greater social support (Gulick, 1994; McIvor, Riklan, & Reznikoff, 1984; O'Brien, 1993a) or had higher self-esteem (O'Brien, 1993a; Walsh & Walsh, 1989), reported greater feelings of self-efficacy (Barnwell & Kavanaugh, 1997; Wassem, 1992), exhibited less emotional distress, a higher level of functioning, and better adjustment to their disease.

Cognitive Correlates of Coping Patterns in MS:

Cognitive deficits are evident on neuropsychological testing in 40% to 65% of patients with MS (Beatty, 1996; Rao, Leo, Bernardin, & Unverzagt, 1991). **Anterograde memory, working memory, complex attention (e.g., divided attention), and information processing speed are the cognitive domains most often affected, although abstraction and proble solving are commonly impaired as well. Remote mem-**

ory and naming may be affected in some patients. Disturbances in speech production are common in MS, but true aphasic syndromes are very rare.

Attempts to relate cognitive dysfunction to coping patterns have met with mixed success. Aikens et al. (1997) found no significant correlation between scores on the Quantitative Mental Status Exam (Mahler et al., 1989) and either emotion-focused or problem-focused coping patterns. Jean et al. (1999) hypothesized that impairments on neuropsychological measures of problem solving and abstraction would be correlated with reduced use of problem-focused strategies to cope with stress. No such association was found. Furthermore, a composite measure of performance on a large battery of neuropsychological tests was not correlated with any aspect of coping. **The absence of an association between a standard measure of abstraction (The Shipley Abstraction Test) and coping was confirmed by Beatty et al.** (1998), **but in the same study a positive correlation between problem-focused coping and performance on a test of practical problem solving was found. This is probably not surprising, because the ability to solve word puzzles or discover rules for sorting cards bears little relationship to managing real world problems of the sort people confront in everyday life.**

In contrast, Arnett et al. reported a correlation between impaired performance on several tests that emphasize information-processing speed and a preference for non-effortful coping. **The influence of cognitive impairment was shown to be independent of level of depression which, as described earlier, was negatively correlated with effortful coping and positively correlated with non-effortful coping.** Arnett et al. suggested that previous attempts to find associations between cognition and coping in MS might have failed because they did not use coping scales that were sensitive to cognitive function. This is certainly possible, but it is equally likely that standard neuropsychological tests, especially measures of problem solving, have limited external validity.

Other Patient Characteristics:

Disability status profoundly affects the cost of caring for patients with MS (Canadian Burden of Illness Study Group, 1998a; Murphy, Confavreux, Haas, et al., 1998a) **and based on patient ratings, reduces the overall quality of life.** Ratings of physical and social function are universally affected by disability status (Brunet, Hopman, Singer, Edgar, & MacKenzie, 1996; Canadian Burden of Illness Study Group, 1998b; Murphy, Confavreux, Haas, et al., 1998b; Solari, Filippini, Mendozzi, et al., 1999); associations of disability with perceived cognitive or mental health impairment are sometimes observed as well.

Of the studies reviewed above that examined associations of psychosocial or cognitive factors with coping patterns, only one (Mohr et al., 1997) reported an association between disability status and coping. **Although not all studies reported data on disability status, the absence of an association in the studies that tested for one suggests that disability status is not an important determinant of coping patterns by patients with MS,** at least as coping has been studied.

In a pioneering study on adjustment to MS, Matson and Brooke (1977) **identified "religion" as an important mechanism that patients with MS employed to cope with their disease,** suggesting that there would be a positive correlation between strength of religious belief and problem-focused coping. Despite this report, as well as anecdotal reports from patients we have studied, Beatty et al. (1998) found no significant correlation between self-reported spirituality and either problem-focused or emotion-focused coping patterns. **Patients who scored high on spirituality were, however, more likely to report seeking social support to deal with stress.**

Caregivers:

Aronson (1997) surveyed 697 patients with MS and 345 caregivers of persons with MS who were residents of the province of Ontario, Canada. **Compared to other disabled persons in the Canadian population, patients with MS reported poorer overall Quality of Life** (QOL) **on the General Social Survey, an instrument developed by Statistics Canada. Low QOL ratings were related to unemployment, severity of disability and fatigue, unstable disease course, and interference with social activities.** Possible relationships between QOL and coping were not studied. **Compared to able-bodied people who were not caregivers, persons who cared for patients with MS also**

reported poorer QOL. Low QOL ratings for caregivers were associated with greater severity of patients' symptoms, longer duration of caregiving, and higher uncertainty of disease course for the patient.

In a smaller study conducted in New Zealand, Knight et al. (1997) studied 55 patients with MS and their spouse-caregivers. **Caregivers experienced a large number of negative effects; the most distressing patient symptoms for the caregiver were motor problems, sudden mood changes, incontinence, pain, and actions by the patient that upset other people. Caregiver burden (total score on a comprehensive questionnaire) was greatest in caregivers who felt they lacked social support and in caregivers who were dissatisfied with their own coping efforts.** Caregiver burden accounted for 25% of the variance in caregiver QOL ratings; no other demographic or disease variables were significant predictors of caregiver QOL, although female caregivers reported higher levels of burden.

The specific coping strategies used by caregivers were examined by Gulick (1995) and O'Brien (1993b). Both studies reported that the number of different coping strategies increased as caregivers experienced more stress, usually because the deteriorating condition of the patients made the patient more dependent. Caregivers employed both problem-focused and emotion-focused strategies and there was no simple relationship between coping strategies and distress.

Modifying Coping in Patients With MS

Foley et al. (1987) examined the effects of a six-session cognitive behavioral therapy program designed to enhance skills needed for self-monitoring daily stressors; this included role-playing to improve skills for coping with the stressors and individualized progressive deep-muscle relaxation training. While some patients received the five-week-long experimental treatment, others received conventional treatment. Subjects in this wait-list control group had the option of subsequently receiving the experimental treatment.

At pretest, both groups showed elevated scores on the BDI, the State-Trait Anxiety Scales (Spielberger, 1983) and the Hassles (Kanner et al., 1981) score. **Following treatment, depression, state anxiety, and the hassles score were reduced for controls. At post-test, the experimental group also exhibited an increase in problem-focused coping while controls showed a nonsignificant decrease.** Scores for emotion-focused coping were not reported and it is not clear whether patients were assigned randomly to groups.

In a two-year randomized trial, Schwarz (1999) compared the effects of explicit coping skills training with another condition; telephone support provided by another patient. **Coping skills training produced gains in psychosocial role performance and increased the sense of wellbeing. These changes were not observed in the peer telephone support condition, but surprisingly patients with affective problems at the onset of the study benefited more from the peer support condition than from the coping skills training. Schwartz suggested that the coping skills training provided a means for helping patients change their priorities and conceptualize the meaning of quality of life.**

A major source of possible assistance in coping with MS is provided by self-help or support groups. Organized by patients, these groups have been aided by the MS Societies in the United States, Canada, and in several other countries for many years. Major cities often have several different groups, often including one specifically for newly diagnosed or mildly affected patients. For example, in Oklahoma, with a total population of about 3.2 million and approximately 2,500 patients with MS, there are 26 MS support groups. What do these groups accomplish? Our review of the literature revealed no published studies on the subject.

Taking Coping Research to the Clinic:

We believe that the existing research (including our own) on coping by patients with MS and their caregivers offers little of practical value to the clinician. **Coping with real world problems is a dynamic, continuous process that requires the successful person to deploy different coping strategies for different problems and to formulate and work toward long-term goals while at the same time being able to shift attention to a threat that demands immediate attention.** A key ingredient is flexibility, an attribute that is not well captured by existing research designs; which

essentially attempt to reconstruct a feature-length movie from 1 or 2 snapshots.

Nothing in the literature suggests that the overall process of coping with life is qualitatively different for patients with MS and their families than for anyone else. The characteristics of the disease, except in its mildest form, almost guarantee that the magnitude and frequency of significant stressors will be greater for patients and their family members than for individuals and families that do not have to contend with chronic neurological disease.

Although we cannot offer an exact recipe for how to help your patients with MS and their families cope with their disease, here are some suggestions that should improve your effectiveness.

Be Informed About MS

Many MS patients are very well informed about recent developments in MS research. Although some read the primary neurological literature, most get their information from the National Multiple Sclerosis Society (NMSS), which publishes brochures on various problems associated with MS (e.g., incontinence, fatigue, cognitive loss) as well as results of ongoing clinical trials and basic research. Many local chapters reprint this information in their newsletters or you can get it from the NMSS website (www.nmss.org). Pharmaceutical companies that market the ABC drugs have their own websites.

Stay Informed of Medication Use

Frequently, patients with MS take a plethora of prescription and nonprescription drugs to improve bladder control and relieve pain, fatigue, spasticity, or depression. Use of special diets, potions, or unusual treatments, such as being stung by bees, have been popular in the past. The use of alternative medicine (usually in association with traditional medicine) is common. Many of these agents can have psychoactive effects, which you will need to consider in planning your treatment. For example, the antidepressant amitriptyline (Elavil) can impair memory; corticosteroids can induce manic reactions in some patients and depression in others. Furthermore, many patients will regard you as the "doctor" and expect that you have knowledge of the drugs they are taking.

Suggested Assessments

Depression. The BDI or the depression scale of the MMPI are widely used, but both contain questions about vegetative signs that can be symptoms of depression, or direct consequences of MS. We prefer the Chicago Multiscale Depression Inventory (Nyenhuis, Luchetta, Yamamoto, et al., 1998), which has separate scales for mood and vegetative signs. Serious depression in an MS patient demands appropriate treatment; either pharmacologic treatment, preferably with one of the SSRIs (e.g., Zoloft, Prozac), or with a proven psychological therapy such as cognitive-behavior therapy.

Fatigue. Use the Fatigue Severity Scale (Krupp, LaRocca, Muir-Nash, & Steinberg, 1989) to quantify this symptom, which is common in MS and a major cause of retirement from the workforce.

Cognition. Mild cognitive deficits are common in MS and may appear soon after diagnosis. Impairment in cognition contributes to premature retirement. **Furthermore, especially early in the course of the disease when physical disability is mild, employers, spouses, and other family members may mistake lapses in attention and memory for intentional acts of malingering designed to gain sympathy and escape responsibility.**

Although a complete neuropsychological evaluation performed by someone who is experienced in evaluating patients with MS is desirable, if time and other resources are short, a brief screening battery can be given. Both the Screening Examination for Cognitive Impairment (SEFCI; Beatty, Paul, Wilbanks, et al., 1995) and the Brief Repeatable Battery (BRD; Rao, 1990) can be given in less than 30 minutes by persons with limited training; both tests have acceptable sensitivity and specificity.

Self-Esteem. This can be assessed by clinical interview or with a test such as the Tennessee Self-Concept Scale (TSCS; Pitts, 1965) or the Coopersmith Self-Esteem Inventory (CSEI; Coopersmith, 1984).

With this information in hand, you are ready to begin therapy. What you will try to accomplish depends on the amount of time that can be devoted to the case, your own philosophical and theoretical orientation to therapy, the patient's view of the major problem, as well as the referral question, if this is relevant.

Cutting across all of the above considerations is the concept of clinician as educator. Despite the widespread availability of readily understandable information about the disease from the NMSS, many patients and their caregivers have unrealistic expectations. Both patients and caregivers may hold catastrophic prophecies about the near future or they may engage in almost complete denial. Helping the patient and the family attain a more realistic view of the patient's disease and the current and near-term difficulties that it poses may be the most important contribution the clinician can make to effective coping. This educational function is especially important for recently diagnosed patients and their families. They may not fully appreciate that emotional and cognitive changes, as well as increased susceptibility to fatigue, are real symptoms of MS, and that these consequences can often be mitigated by simple lifestyle modifications, such as increased rest and adjusting one's daily schedule so that the most demanding tasks can be performed when fatigue is at a minimum.

Once the assessment of the patient's psychological and cognitive status is complete, **an information-sharing session including the patient, spouse, and possibly other family members should be considered. This is the best way to ensure that patients and key family members have a common understanding of the patients' current situation and the prospect for the future.**

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

17. Research has shown that coping with life stressors may be focused either inward or outward. A coping strategy that is directed externally at the source of the stress is referred to as:

A. Emotion-focused coping.

B. Strategy-focused coping.

C. Milieu-focused coping.

D. Problem-focused coping.

18. According to the stress-appraisal model of coping, coping is seen as:

A. The ability to remain happy in stressful situations.

B. Cognitive and behavioral efforts to reduce distress.

C. A belief that one can overcome life stress.

D. Actions that help one to avoid reencountering a stressor.

19. Compared to healthy subjects, research has shown that MS patients:

A. Are much better at coping with daily stress.

B. Use more emotion-focused strategies in dealing with daily stress.

C. Are no different in their coping patterns or self-efficacy in coping with daily stress.

D. Are much worse at coping with daily stress.

20. Around 40%–65% of MS patients show deficits on neuropsychological tests. One area often seen to be deficient is:

A. Figure drawing.

B. Counting.

C. Anterograde memory.

D. Simple Attention.

DIRECTIONS
Volume 11 Lesson 6

Eye Movement Desensitization and Reprocessing (EMDR): Clinical Implications of an Integrated Psychotherapy Treatment

Francine Shapiro, PhD and Louise Maxfield, MA

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Introduction

In this lesson clinicians will gain awareness of the history and efficacy of EMDR, learn that information processing of seminal events may have a beneficial effect in the treatment of a variety of disorders, recognize how EMDR is an integrative treatment, and understand the eight-phase treatment protocol and the importance of each phase in the application of EMDR.

Eye Movement Desensitization and Reprocessing (EMDR) **is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories** (Shapiro, 1989a, 1989b). EMDR integrates elements of many effective therapies, including psychodynamic, cognitive behavioral, body-oriented, person-centered, and interactional therapies (Allen & Lewis, 1996; Bohart, in press; Brown, in press; Fensterheim, 1996; Lazarus & Lazarus, in press; Manfield, 1998; Wachtel, in press). Moreover, EMDR, with its brief exposures to traumatic or associated material, dual stimulation, and therapeutic protocol, is a distinctly different form of therapy, activating a natural, internal information processing system that moves the individual toward healing (Shapiro, 1995/2001, 1999, in press).

This lesson provides an overview of EMDR and its clinical applications. Background information about the history of EMDR and its established efficacy is presented. This is followed by a summary of the Adaptive Information Processing model, which purports to explain how the adequate processing of seminal events may have a beneficial effect in the treatment of a variety of disorders. Next a detailed description of each phase of the EMDR standardized protocol is provided, highlighting the procedures, assumptions, and clinical observations that currently guide EMDR clinical practice. Finally, the clinical implications of EMDR are discussed, with an examination of client response, and the application of EMDR to a variety of mental disorders is considered.

Background

EMDR is a therapeutic process which appears to facilitate the accessing and processing of traumatic memories and to bring these to an adaptive resolution, indicated by desensitization of emotional distress, reformulation of associations and beliefs, and relief of accompanying physiological arousal. During EMDR the client attends to emotionally disturbing material in sequential doses while simultaneously focusing on an external stimulus. Therapist-directed eye movements are the most commonly used external stimulus but a variety of other stimuli including hand-tapping and aural stimulation are often used (Shapiro, 1991, 1994b, 1995/2001). This dual (external/internal) focus is combined with frequent brief periods of focusing on relevant associations under direction of the therapist. The use of external stimuli was initiated on the basis of personal experience (see Shapiro 1989a, 1995/2001; Shapiro & Forrest, 1997). However, previous researchers had already reported on the correlation of eye movements with disturbance and consequent shifts in cognitive content (Antrobus, 1973; Antrobus, Antrobus, & Singer, 1964).

EMDR was introduced into the field of psychology by means of a controlled outcome study (Shapiro, 1989a) that assessed a one-session treatment of disturbing memories associated with symptoms of posttraumatic stress disorder (PTSD). **EMDR is now the most researched treatment for PTSD** (van Etten & Taylor, 1998), with 16 randomized controlled studies published in peer reviewed journals. Its apparent efficacy in PTSD treatment has become widely recognized (Chambless et al., 1998; Chemtob, Tolin, Pitman, & van der Kolk, 2000; Hembree & Foa, 2000; Shalev, Foa, Keane, & Friedman, 2000). **Several studies calculated the decrease in PTSD diagnosis, which was substantial, ranging from 80% to 90%** (Marcus, Marquis, & Sakai, 1997; Rothbaum, 1997; Wilson, Becker, & Tinker, 1997), **while others reported twice the effect sizes of active control conditions** (e.g., Scheck, Schaeffer, & Gillette, 1998). EMDR appears to be as effective as cognitive behavior therapy, and more efficient, requiring less treatment time (Ironson, Freund, Strauss, & Williams, in press; Lee & Gavriel, 1998; van Etten & Taylor, 1998; Vaughan et al., 1994).

Although there are numerous anecdotal and case reports of EMDR's effectiveness with other anxiety disorders, such as obsessive compulsive disorder (Whisman, 1996), **panic disorders** (Nadler, 1996), **and phobias** (Marquis, 1991), **its efficacy with these disorders has yet to be empirically established.** The application of the entire protocol specified for phobias has revealed positive effects in reported research (De Jongh & Ten Broeke, 1994, 1996, 1998; De Jongh, Ten Broeke, & Renssen, 1999; Ten Broeke & De Jongh, 1993) but when the protocol was truncated in controlled studies so that only some components were used, the reported effects were equivocal with phobias (Muris & Merckelbach, 1997; Muris, Merckelbach, Van Haaften, & Mayer, 1997; Muris, Merckelbach, Holdrinet, & Sijsenaar, 1998) and panic disorder (Feske & Goldstein, 1997; Goldstein, de Beurs, Chambless, & Wilson, in press; Goldstein & Feske, 1994). **There is preliminary evidence that EMDR may be effective in the treatment of social anxiety** (Bauman & Melnyk, 1994; Foley & Spates, 1995; Gosselin & Matthews, 1995; Maxfield & Melnyk, 2000). In future research it will be important to test the entire integrative EMDR protocol in an application which provides a full course of treatment.

Possible Mechanisms of Action

Shapiro's (1995/2001) **Adaptive Information Processing model assumes that humans possess a physiologically based information processing system**

which, under normal circumstances, responds to and resolves everyday, minor disturbances. Information is processed to an adaptive state, where connections to appropriate associations are made, emotional distress is relieved, experiences are used constructively, and learning takes place. Information is understood to be stored in a system of memory networks, which contain related memories, thoughts, images, emotions, and sensations. The networks are linked in associated channels of information. Processing (or reprocessing) is defined as the forging of the associations required for learning to occur as the information pertaining to an event is "adaptively resolved."

Sometimes experiences which are traumatic, egodystonic, or which evoke intense emotional distress, are inadequately processed. It is hypothesized that during a serious traumatic event, perceptions of the experience (e.g., the rapist's face, breath, etc.) are stored in a "state-dependent" fashion, so that they are most accurately recalled when the individual is in the same or similar physiological state and the information may remain in neurobiological stasis (see van der Kolk, Greenberg, Boyd, & Krystal, 1985). It appears as though the system becomes imbalanced, unable to appropriately assimilate the information, which becomes "locked in the brain" in the form it was input. Other severely stressful events can be inadequately processed and thus contribute to the development of a variety of mental disorders and the subsequent impairment of physical, emotional, and mental health, and life function. It is assumed that such experiences are also dysfunctionally stored in state-dependent form, inherently containing affective, physiological, and cognitive elements that need to be addressed (Shapiro, 1995/2001, 1998, 1999, in press). **Therefore, it is conjectured that adequate processing of seminal events will have a beneficial effect in the treatment of a variety of disorders.**

There are several hypotheses that attempt to explain how eye movements and other dual attention stimulation may enhance information processing: (1) They disrupt the function of the visuospatial sketchpad and interfere with working memory (Andrade, Kavanagh, & Baddeley, 1997)**; (2) they elicit an orienting response, with an instinctive interest-excitement affect creating new associative links with the dysfunctionally stored information** (Armstrong, & Vaughan, 1996; Lipke, 2000; MacCulloch, Feldman, & Wilkinson, 1996)**; (3) they evoke a relaxation response, or a new set of physiological states and responses, creating new associative links with the dysfunctionally stored information, and allowing for the integration of new information** (Shapiro, 1995/2001; Wilson et al., 1996)**; (4) they activate neurological processes that mimic REM sleep-type function and its information processing mechanisms** (Shapiro, 1989, 1995/2001; Stickgold, in press).

Although a number of component studies have attempted to investigate the dual attention stimulation within the clinical methodology, methodological flaws prevent any definitive conclusions (see Chemtob et al., 2000; Feske, 1998; Shapiro, 1999). Typically such studies used small samples with inadequate power, selected inappropriate controls, and used truncated procedures (e.g., Carrigan and Levis, 1999 provided 145 seconds of treatment). Although component studies with clinically diagnosed subjects (Montgomery & Ayllon, 1994; Renfrey & Spates, 1994; Wilson, Silver, Covi, & Foster, 1996) provide preliminary evidence that the eye movement condition appears more effective than control conditions, these findings are also limited by methodological problems (see Shapiro, 1995/2001 for a comprehensive review).

Clinical Application of EMDR:

EMDR is hypothesized to facilitate the accessing of the traumatic memory network and to activate the information processing system with its inherent self-healing processes. **The reprocessing of the dysfunctionally stored information results in comprehensive learning, which includes the elimination of emotional distress and the development of cognitive insights.**

Contrary to a common misconception, EMDR is not a simple, by-the-book procedure dominated by the use of repeated eye movements (despite its name), but rather an integrated form of therapy incorporating aspects of many traditional psychological orientations (Shapiro, 1995/2001, in press). EMDR contains a unique combination of elements, all of which are posited to enhance information processing and thus

contribute to treatment outcome. **Clinical evidence indicates that application of the full protocol may be essential for optimal outcome, and that truncating the procedure by eliminating various procedural elements can result in poorer outcomes. Shapiro** (1999) **and colleagues reviewed EMDR phobia outcome studies and determined that those using fewer than half of the required elements had poorer outcomes than those which used more than half of the protocol elements.**

The Eight Phases of EMDR Treatment

In the following description of the eight treatment phases, the procedures, assumptions, and clinical observations that currently guide EMDR clinical practice are highlighted (for further details, see Shapiro, 1995/2001). Because supervised training is mandatory for appropriate use, only a brief descriptive outline is provided here. **The following summary is not a treatment manual and is not intended to replace the clinical training that is essential for client safety and adequate treatment effects.**

Phase One: Client History and Treatment Planning

During the first phase of EMDR treatment the therapist takes a full history, assesses the client's readiness for EMDR, and develops a treatment plan. The therapist evaluates aspects such as diagnosis, comorbidity, suicidality, dissociation, existing support system, life stability, presence of current stressors, physical health, secondary gain, and substance use. Although the obtaining of a full history and evaluating the entire clinical picture is a procedure followed in most psychotherapies, in EMDR it has additional theoretical and clinical importance, because it is used by the therapist to identify suitable targets for treatment.

The EMDR therapist chooses targets according to theories about information processing. It is assumed that:

- **Processing may be accompanied by intense emotions.**
- **Processing of memory networks may activate related prior incidents.**
- **If related early events are not processed, treatment may be incomplete, and possibly ineffective.**
- **Treatment effects will likely generalize to similar events, but not to unrelated incidents.**
- **Processing should include a focus on past events, present stimuli, and future situations or behaviors.**

Therefore treatment targets can include affect management resources, recent distressing events, current situations that stimulate emotional disturbance, related historical incidents, and the development of specific skills and behaviors that will be needed by the client in future situations.

Targets are prioritized for sequential processing. The clinician's choice of targets must take into account certain patterns of generalization that appear to be related to memory networks. Treatment effects tend to generalize from memory to memory only when features are similar (Fairbank & Keane, 1982). **If a cluster of similar experiences (e.g., several related instances of molestation by the same perpetrator) is known to exist, only one representative event from this group may need be treated. Such generalization of treatment effects should not be expected if the client reports a variety of dissimilar events and triggers and thus each of these must be reprocessed separately** (Shapiro, 1995/2001).

Clinical Vignette:

John was a 30-year-old single man who developed PTSD after a car accident. He became immobilized by fear, developed a driving phobia, and was unable to return to work. During the assessment session, he disclosed that when he was a child, his mother had repeatedly and violently beaten him. Since the accident John was having nightmares of being trapped. John was socially isolated, unhappy at work, and used alcohol to relax. The

therapist decided to target affect management, and then, in chronological order, the childhood abuse, the accident, and the related phobia.

Phase Two: Preparation

Phase Two involves establishing an appropriate therapeutic relationship, setting reasonable levels of expectation, and educating the client regarding his/her symptoms. Preparation for EMDR includes education about the EMDR process and ensuring that the client has demonstrated adequate self-control and affect management skills. It is assumed that avoidance behavior is likely to be manifested by the anxiety-disordered client at the outset of treatment and that it will therefore be necessary to address this issue before serious attempts at reprocessing can begin. For clients with deficits in these areas, this phase of treatment may be extensive.

Self-control and self-calming techniques are an important element of treatment and are used to "close" incomplete sessions and to maintain client stability between and during sessions. Therapists can use EMDR to assist in the development of resources and strengths, and to establish client safety and stabilization (see Shapiro, 1995/2001). This resource enhancement work combines relaxation, imagery, and EMDR to assist the client in developing new skills and strengths. **For example, EMDR is commonly used to enhance "safe place" visualization.** This involves adding dual attention stimulation, according to certain interactive clinical guidelines, while the client imagines a past memory or fantasy that evokes a feeling of safety. Client reports indicate that EMDR amplifies the sensory content and somatic experience of the visualization.

During Phase Two, the client is prepared to "just notice whatever happens" and to maintain a balanced observation/participation position. This is encouraged by the use of helpful metaphors (e.g., to imagine themselves as being on a train and to think of the disturbance they may be experiencing as merely passing scenery).

Clinical Vignette:

John had no concept of a "safe place" and no ability to calm himself when he became distressed. For John, treatment in this phase focused on the identification and development of resources such as self-soothing, courage, endurance, and self-efficacy.

Phase Three: Assessment

In the third phase the client and therapist select a specific memory to target during the session, and identify the associated mental image, beliefs, emotions, and physical sensation, taking baseline measures of responses. The assessment phase contains three steps designed to fully activate the memory network.

First, the representative and/or most salient mental image of the event is identified. In the second step, the therapist helps the client to identify the current negative belief about him/herself that is related to the target memory. Negative cognitions are beliefs such as "I'm powerless," or "I am worthless." Sometimes clients express beliefs about themselves that they may never have previously spoken aloud. This begins the process of recognizing the irrationality of their cognitive interpretation of the event, and its impact on current self-concept. After this, the therapist helps the client to identify a desired positive belief that expresses a desired sense of empowerment or value, such as "I'm competent" or "I'm lovable." The client rates the accuracy of this positive belief on the Validity of Cognition Scale (VOC; Shapiro, 1989a), where 1 represents "completely false" and 7 represents "completely true"; this provides both client and clinician with a baseline with which to assess the appropriateness of the chosen cognition and a given session's progress, thereby further promoting client treatment adherence. It also serves to increase the client's awareness of his/her cognitive distortion and offers a "light at the end of the tunnel," thereby encouraging and motivating him/her to stay with treatment.

In the third step, the image and the negative belief are paired to facilitate access to the stored memory of the trauma. The client identifies the emotions that are elicited and rates the level of distress on the Subjective Unit of Disturbance (SUD; Wolpe, 1958) **scale, where 0 is "calm" and 10 is "the worst possible distress." Explicitly labeling the emotion allows the clinician to:**

- **Offer the appropriate verbal support.**
- **Anticipate any beliefs about emotions that might block processing and that need to be addressed.**
- **Establish a response baseline.**
- **Recognize changes in the type of emotion experienced during the session, this is also helpful for the client.**

Next the client identifies and locates the body sensations that accompany the disturbance. **The therapist's simple acceptance of the client's low VOC and high SUD scores indicates to the client that there are no expectations, and demonstrates an acceptance of the client in his/her present state.**

Clinical Vignette:

John chose for his target image a mental picture of his mother's angry face, and the belief "I'm powerless." He chose for his positive cognition, the belief "I'm a competent person," and rated this at 2 on the VOC scale. Combining the image with the negative belief elicited powerful emotions of shame, anger, and sadness. John rated his feelings of distress at 9 on the SUD scale, and described the feelings as located in his abdomen. He commented on how deeply his sense of self was rooted in early experiences with his mother.

Phase Four: Desensitization

During this phase of EMDR, an accelerated processing, or learning takes place. The client is instructed to focus on the visual image, the identified negative belief, and body sensations, and then to "Let whatever happens, happen." S/he maintains this internal focus while simultaneously moving the eyes from side to side for 15 or more seconds, following the therapist's fingers as they move across the visual field. After the set of eye movements, the client is told "Blank out (Let go of) the material, and take a deep breath," and then is asked "What do you get now?" Depending upon what emerges (e.g., image, thought, sensation, or emotion) the clinician then guides the client's attention to the appropriate target for the next set of eye movements.

This cycle of alternating focused exposure and client feedback is repeated many times and results in rapid effective information processing and is accompanied by multiple shifts in affect, physiological states, and cognitive insights (e.g., McCullough, in press; Shapiro, 1995/2001; Tinker & Wilson, 1999). Because EMDR uses a nondirective, free-association method, some clients spend very little time exposed to the details of the presenting problem. **They may rapidly and spontaneously access a succession of related thoughts, images, emotions, associations, and memories, and move through these in an integrative way. If processing stalls, the therapist uses one of a number of specialized interventions that are worded and timed in a specific manner to reactivate processing** (see Shapiro, 1995/2001). For example, the therapist may ask the client to focus, with dual attention stimulation, on a past experience that serves as a counter example, thus creating new associations and mimicking spontaneous processing. The SUD level is usually not reassessed until emotional, physical, and cognitive resolution is apparent. A SUD rating of 0 or 1 generally indicates completion of this phase. Other dual attention stimuli (hand-tapping, aural stimulation) can replace eye movements.

Clinical Vignette:

In one session during this phase, John focused on a childhood incident in which his mother had locked him in the closet. During processing, he accessed many other memories of his mother's cruelty. He recalled his mother beating his little sister and how powerless and guilty he felt. He remembered his mother blaming him, saying that he deserved to be beaten. After approximately 50 minutes of processing, focusing on such related material, John reported that there were no longer negative feelings associated with the closet incident. He provided a SUD rating of 0.

Phase Five: Cognitive Installation

In this phase, the focus is on incorporating and increasing the strength of the positive cognition designated to replace the original negative self-belief. This phase allows for the expression and consolidation of the client's cognitive insights. Sometimes a more therapeutically beneficial positive belief may have

emerged during the Desensitization Phase. Regardless of its origin, the most enhancing positive cognition is elicited and paired with the previously dysfunctional material during the sets of stimulation until a VOC of 6 or 7 is achieved. This phase allows for the expression and consolidation of the client's cognitive insights. The therapist encourages the client to continue until strong confidence in the positive cognition is apparent. For many clients there is a profound shift in self-concept, integrating self-acceptance with new positive and realistic perceptions of the self.

Clinical Vignette:

When John paired his positive belief, "I'm a competent person" with the original targeted image of his mother's face, he noticed that the image no longer had any emotional power. After several sets of eye movements, during which these two elements were paired, John reported a strong sense of confidence and competency, and reported a VOC of 7.

Phase Six: Body Scan

In phase six, the clinician asks the client, while thinking of the image and the positive cognition, to notice any tension or unusual sensations in his/her body. **Because dysfunctionally stored information is also often experienced physiologically, processing is not considered complete until the client can bring the traumatic memory into consciousness without feeling any body tension.** Any sensations found in the body scan are targeted with more eye movements; this continues until the tension is relieved. Sometimes such body sensations are linked to aspects of the memory network that have not yet been processed.

Clinical Vignette:

When John scanned his body for any discomfort, he noticed that his wrists hurt. This sensation was then targeted, and he remembered how his mother, on one occasion, had gripped his wrists, holding his hands above his head, to immobilize him during an assault. After targeting this body sensation, the pain in John's wrists disappeared, and he reported feeling free, powerful, and strong.

Phase Seven: Closure

The therapist assesses whether the material has been adequately worked through, and if not, assists the client with the self-calming interventions developed in Phase Two. In addition, clients are debriefed on their processing experience and told what to expect and what to do between sessions. These instructions include how to maintain a journal and to record any disturbance that arises, such as nightmares or flashbacks, and related material such as insights, memories, emotions, and dreams.

The journal parallels the assessment stage of treatment and facilitates the process of accessing appropriate targets in future sessions. Further, the client's acts of recording and recognizing patterns of reaction appear to encourage a sense of self-mastery and observation during subsequent in vivo exposure to real life disturbing conditions. The self-control techniques are used by the client to reestablish a state of emotional comfort once recording has been completed. These activities facilitate between-session stabilization.

Phase Eight: Reevaluation

Reevaluation takes place at the beginning of every subsequent EMDR session. The therapist checks with the client to assure that the treatment gains have been maintained by accessing the previously processed targets and ascertaining the present emotional, cognitive, and physiological responses. The clinician reviews the client's journal to identify appropriate targets and assesses the degree to which treatment effects have generalized and/or need further attention. Successful treatment can only be determined after sufficient reevaluation of reprocessing and behavioral changes.

The goal of EMDR therapy is to produce the most substantial treatment effects possible in the shortest period of time, while simultaneously maintaining client stability (i.e., preventing emotional overload) within a balanced system (e.g., appropriately integrated with his/her larger family and social systems). Therefore, it is essential that behavioral feedback is evaluated over time. The eight phases of treatment may be completed in a few sessions, or over a period of months, depending upon the needs of the client and/or the seriousness of the pathology.

Clinical Vignette:

Over a number of sessions, John targeted the physical abuse and emotional rejection by his mother. When this work was completed, there were two EMDR sessions focusing on the car accident, which resulted in the complete resolution of the accident-related PTSD. The phobia disappeared after a session in which imagined future driving incidents were targeted. Treatment was terminated after a final EMDR session in which John consolidated realistic positive self-perceptions, pairing these with future goals, and formulated a self-monitoring plan to assess any future therapeutic needs.

Clinical Implications

EMDR appears to be a rapid and effective treatment. In their meta-analysis of PTSD treatment, van Etten and Taylor (1998) observed that EMDR treatment used significantly fewer sessions than behavior therapy (4.6 vs. 14.8) and took significantly less time (3.7 vs. 10.1 weeks). **Three or four EMDR sessions are often sufficient to eliminate PTSD for civilian clients, especially those who have experienced a single trauma** (Marcus et al., 1997; Rothbaum, 1997; Scheck et al., 1998; Wilson, Becker, & Tinker, 1995, 1997).

Combat veterans and those who have suffered multiple traumas also respond well to EMDR, but appear to require a longer course of therapy. **Twelve EMDR sessions reduced the symptoms of a group of Vietnam veterans so that 77% no longer met diagnostic criteria for PTSD, with treatment effects maintained at nine month follow-up** (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998).

EMDR may be better tolerated by some clients than traditional exposure therapies. This may be due to its structured, client-directed process and to the low dosage of exposure to painful material (Rogers & Silver, in press; Shapiro, 1995/2001). Researchers investigating combat veterans in randomized studies have generally indicated that EMDR was better tolerated by patients than exposure therapy, and that it was preferred by both clients and therapists (Boudewyns & Hyer, 1996; Boudeywns, Stwertka, Hyer, Albrecht, & Sperr, 1993; Pitman et al., 1996). When Rogers and colleagues (1999) examined differences in treatment processes, they found that although SUD ratings were taken more often during the exposure condition, EMDR resulted in a significantly greater decrease in SUD ratings, with a mean SUD rating for EMDR at session closure of 0.4. This rapid drop in SUD ratings suggests that EMDR may be a less distressing procedure. EMDR also appears to correlate with a decrease in intrusions and self-monitored distress.

Further, EMDR does not have lengthy required homework assignments and therefore may be more acceptable to clients who have difficulty complying with treatment regimes (Scott & Stradling, 1997).

Although empirical evidence for EMDR has only been established for the treatment of PTSD, positive reports have been published on the application of EMDR to the treatment of personality disorders (Fensterheim, 1996; Heber, Kellner, & Yehuda, in press; Korn & Leeds, in press; Manfield, 1998) dissociative disorders (Lazrove & Fine, 1996; Paulsen, 1995), a variety of anxiety disorders (De Jongh & Ten Broeke, 1998; De Jongh, Ten Broeke, & Renssen, 1999; Goldstein & Feske, 1994; Nadler, 1996; Shapiro & Forrest, 1997), and somatoform disorders (Brown, McGoldrick, & Buchanan, 1997; Grant & Threlfo, in press). Controlled research is needed to evaluate the efficacy of the application of the entire EMDR protocol within the context of the potential special needs of the particular population. For complex disorders such as substance abuse and dissociative disorders it is important to incorporate EMDR within an integrative treatment plan.

The Adaptive Information Processing theory suggests that EMDR should be effective for disorders which have presumed underlying etiological events. For example, Brown and colleagues (1997) evaluated the application of EMDR in seven consecutive cases of Body Dysmorphic Disorder (BDD), which has been reported to be extremely resistant to support and insight-oriented psychotherapy (Phillips et al., 1993). There is some preliminary evidence of effectiveness for cognitive behavior therapy using exposure and cognition challenging techniques (Rosen, Reiter, Orosan, 1995; Neziroglu, McKay, Todaro, & Yaryura-Tobias, 1996; Veale et al., 1996; Wilhelm, Otto, Lohr, & Deckersbach, 1999). Such treatment typically takes 8–20 sessions, with results improved by a six-month maintenance program (McKay, 1999). In contrast, when EMDR was used to process the etiological mem-

ory, Brown and colleagues (1997) reported the elimination of BDD in one to three sessions for five of seven consecutive cases. While this indicates that EMDR holds promise in the treatment of this disorder, future controlled research should include a greater number of sessions to evaluate the comprehensive clinical picture.

Conclusion

Although EMDR contains a number of unique elements, including brief exposures to associated material accompanied by eye movements (or other dual attention stimulation), it is an integrative approach which blends aspects of all the major psychological orientations (Fensterheim, 1996; Shapiro, 1995/2001, 1998, 1999, in press). EMDR has been constructed to achieve comprehensive effects with the full range of clinical populations and consequently contains procedural elements which incorporate aspects of psychodynamic (Wachtel, in press), cognitive behavioral (Smyth & Poole, in press; Zangwill & Young, in press), experiential (Bohart, in press), and physiological (Siegel, in press; van der Kolk, in press) therapies. As such, **elimination of procedural steps and alterations of standardized protocol can have a detrimental effect on the achievement of treatment effects depending upon the particular characteristics of a given population. Therefore, regardless of the efficacy of truncated versions of EMDR procedures and protocols with individual subjects or populations, researchers and clinicians should note that it is codified as a standardized eight-phase approach. In order to determine its applicability to a given population, EMDR should be tested with all phases and procedures intact** (Maxfield & Hyer, in press).

Currently EMDR has established efficacy for PTSD (Chemtob et al., 2000; Shalev et al., 2000), and there are many indications that EMDR is effective with a variety of other disorders, especially those in which there is a known experientially based etiology. EMDR appears to facilitate the accessing of the salient memory network and to efficiently activate the information processing system with its inherent self-healing processes. The rapid documented treatment effects (e.g., Marcus et al., 1997; Rothbaum, 1997; Scheck et al., 1998; Wilson et al., 1995, 1997) and the indications of correlated physiological effects (Heber & Yahuda, in press; Levin et al., 1999) suggest that EMDR should be considered a first-line treatment for the alleviation of psychological suffering. Controlled research is suggested to determine comparative efficacy in the treatment of a variety of clinical complaints for which it is currently applied.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

21. Regarding the empirical investigation of EMDR treatment of PTSD:

A. EMDR is the most researched psychotherapy for PTSD.

B. Several studies reported an decrease of PTSD diagnosis of 80%–90% in single trauma victims after 3–4 sessions.

C. There is preliminary evidence that EMDR may be effective in the treatment of social anxiety.

D. All of the above

22. The Adaptive Information Processing Model states that:

A. During processing, attention must be restricted to the specific memory that is being treated.

B. Information is understood to be stored in a system of memory networks, which contain related memories, thoughts, images, emotions, and sensations.

C. Severe trauma is the only type of experience which can remain inadequately processed and contribute to the development of mental disorders.

D. None of the above

23. Which one of the following statements regarding EMDR is correct?

A. The presenting distress should be the first treatment target.

B. Emotional stabilization should be accomplished before trauma processing begins.

C. Phobias can only be eradicated by utilizing a hierarchy.

D. Only two or three sessions are required for treatment of multiply traumatized persons.

24. When determining EMDR's applicability to a given population:

A. It is appropriate to experiment by using only one or two components.

B. Eye movements can be added to regular therapy.

C. EMDR should be tested with all phases and procedures intact.

D. It is not necessary to use the eight-stage protocol.

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DIRECTIONS
Volume 11 Lesson 7

Counseling Strategies With Women Survivors of Child Sexual Abuse

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There has been some debate over the use of the term "victim" versus "survivor." In this paper, women with histories of CSA will be described as "survivors." This terminology is consistent with the theoretical assumptions of this treatment, which acknowledge painful events in the woman's history while recognizing the desire to move forward in her life.

Introduction

Mental health care professionals, educators, politicians, and community advocacy groups have focused a great deal of attention on the prevention and treatment of child sexual abuse (CSA). In the mental health field, an associated effort has been made to help children and parents live in safer environments and cope with abuse when it occurs. Despite these efforts, many families do not have access to appropriate resources. And, for a number of reasons, some adult survivors of CSA who present to therapists have never had treatment. Though there has been increased attention to the treatment of CSA survivors over the last two decades, many women seeking treatment related to a history of abuse reach middle age with no prior treatment history. Furthermore, the recent controversies regarding recovered memories and the significance of an abuse history may have prevented some women from seeking therapy.

Despite some disagreement over the exact figures, many surveys reveal that 15%–34% of women in the general population report a history of CSA (Briere & Runtz, 1989; Finkelhor, et al., 1990; Wyatt et al., 1999). Within some clinical populations, as many as 35% to 75% of women report having experienced sexual abuse during their childhood (Carlin & Ward, 1992; Jacobson, 1989; Palmer, et al., 1992). Although CSA is fairly prevalent, research on treatment has been somewhat slow to develop. Treatment development has been influenced by society's recognition of the existence of CSA and its effects on individuals, debates regarding causal relationships between CSA and long-

term psychological distress, and impact of CSA versus other variables in the development of long-term psychological distress.

Recognition of CSA in American society has been inconsistent. Enns, McNeilly, Corkery, and Gilbert, (1995) described how "public recognition of trauma and its impact on victims has tended to increase alongside political movements that support human rights; attention to these issues wanes as more conservative trends emerge" (p.186). These trends influence whether interpersonal violence is considered a problem with existing social structures (times of political activism) or a problem with individuals (times of conservatism). The perspective adopted may affect whether people believe treatment and research should be directed at the environment, the individual, or whether the problem deserves recognition at all. Regardless, CSA survivors continue to present to mental health professionals. While the goal of this paper is to describe counseling strategies for individuals with histories of CSA, it is important to acknowledge the sociohistorical contexts that influence the behaviors of therapists, clients, and the larger population.

The objective of this lesson is to present a cognitive-behavioral approach to treating women survivors of CSA. Our work is guided by a contextual behavioral understanding of experiential avoidance and the problems associated with that phenomena (Hayes et al., 1996). Assessment and treatment strategies will be introduced, and current issues in the treatment of CSA survivors, including the issue of whether to provide treatment at all, will be discussed.

Causality

Although research has indicated that some CSA survivors experience greater psychological distress than women with no history of CSA, the evidence does not definitively support a direct causal relationship between child sexual abuse and adult psychological problems. Thus, symptoms such as depression, anxiety, and somatization cannot be described accurately as "effects" of CSA; the term "correlates" more accurately reflects what has been found in the literature on CSA thus far. **To clarify, data does suggest a causal relationship between CSA and long-term mental health problems for some individuals.** Follette (1994) suggests discussing CSA as a "distal risk factor that can lead to the development of a number of painful and serious adult difficulties" (p. 256). Describing CSA as a risk factor is one way to discuss long-term correlates in a manner that is consistent with research findings. More research is needed to precisely identify the relationships among long-term correlates and CSA. A significant proportion of the current data is based on survivors who seek treatment, while information about survivors who do not seek treatment is far from complete.

The influence of factors besides CSA should also be considered regarding long-term problems. For example, it may be the combination of abuse and living in an invalidating parental environment that contributes to psychological distress. **An invalidating parental environment is one in which a child's experiences are belittled, disregarded, criticized or even punished when feelings or thoughts are communicated** (Linehan, 1993). Though knowledge regarding variables that are strongly predictive of the development of long-term psychological distress is incomplete, therapists can proceed to educate clients and each other about what is known at this time.

Given this context of inconsistent public support and developing knowledge in the field, therapists need to be cautious regarding the techniques they use. While a number of clinical texts have been written regarding treatment for CSA, many of these have not been constructed from theoretically and empirically based literature. **Therapeutic techniques such as dream interpretation and age regression that have been described in the literature as treatments for CSA have no empirical support for efficacy with this population.** Therapeutic approaches based on cognitive-behavioral strategies differ in that, while the data for CSA treatment is preliminary, the therapy is guided by a tradition that has worked continuously to refine theory, assessment, and therapeutic techniques through empirical investigations. Moreover, the data on closely related types of traumatic experiences is supportive of a cognitive-behavioral approach.

In efforts to standardize treatment and increase quality control, the American Psychological Association (APA, 1995) published a list of empirically supported treatments for multiple psychological and behavioral problems. Empirically supported treatments are those

that have been investigated multiple times by different investigators and have repeatedly produced outcomes that are superior to placebo and/or are equivalent or superior to an already established treatment (APA, 1995). **Currently, the only empirically supported treatment for trauma (specifically combat and rape trauma) is exposure-based cognitive-behavioral treatment.** Researchers have found that clients in exposure conditions improve significantly more than clients who receive supportive counseling and those who are on a waiting list (Boudewyns & Hyer, 1990; Foa et al., 1991; Keane, et al., 1985).

Population Issues

Although some CSA survivors appear to be resilient and do not develop psychological disturbances related to their abuse, a significant percentage of survivors reporting to mental health professionals describe disturbances such as anxiety, depression, dissociation, and alcoholism related to their abuse. One of the most frequently reported forms of psychological distress that any type of trauma survivor will experience is posttraumatic stress disorder (PTSD). Although there has been controversy among trauma researchers as to the application of this diagnosis to CSA survivors, a great deal of research supports the presence of PTSD symptomatology among survivors (Rowan & Foy, 1993). Some CSA survivors report intrusive thoughts and images of the abuse, nightmares, insomnia, and difficulty concentrating. Individuals may also attempt to avoid trauma experiences by actively thinking about other things or participating in activities that function to numb and avoid thoughts and feelings. Substance abuse, for example, is one type of numbing behavior.

A number of reviews indicate that, in addition to PTSD, CSA survivors have higher rates of depression, personality disorders, eating disorders, somatization, general psychological distress, fearfulness, suicide attempts, alcohol abuse, and low self-esteem (Gorcey et al., 1986; Hernandez, 1995; Mullen et al., 1996; Polusny & Follette, 1995). There is also some empirical evidence suggesting that **CSA survivors report anger, guilt, shame, alexithymia, and difficulties with interpersonal relationships** (Polusny & Follette, 1995). While these data provide important foundations for further research, findings on CSA are still based on preliminary evidence and more longitudinal research is needed.

Contextual/Cognitive-Behavioral Theory of Treatment

The range of strategies that have been developed to treat trauma symptoms in CSA is partly a product of the multitude of theories that explain how CSA affects individuals. Several theories (i.e., psychodynamic, traumatic stress, and cognitive-behavioral theories) have offered models that identify treatment targets and therapeutic approaches. **The basis of the treatment in this lesson uses a behavioral-contextual theory, which will be described briefly.** This approach includes thoughts and feelings in the analysis and can be broadly conceptualized within a cognitive-behavioral framework.

This contextual perspective, which incorporates the concept of "experiential avoidance," is based on work conducted at the University of Nevada, Reno by Hayes and colleagues (see Hayes et al., 1999, for a detailed description). **The concept of experiential avoidance is at the core of our understanding of symptoms related to psychopathology** (Hayes et al, 1996). While many other theories of psychopathology have recognized similar constructs, the use of this concept is newer in behavioral paradigms (Walser & Hayes, 1998). **In the case of abuse survivors, experiential avoidance is defined as the "unwillingness to experience unpleasant internal events such as thoughts and feelings associated with the abuse"** (Follette, 1994, p. 257). **For example, clients may attempt to avoid unwanted thoughts, emotions, and physiological responses through engaging in avoidance behaviors such as drug and alcohol abuse, cutting, and dissociation.** The probability of these behaviors continuing increases if they effectively function to distract the client from the undesirable events she is avoiding. These behaviors may lead to other problematic outcomes. The effects of the alcohol and drugs may weaken inhibitions and lead to greater risk-taking behaviors and a greater risk of revictimization. In her review of the literature, Cooper (1992) noted that the use of alcohol and other drugs has been associated with early onset of sexual activity,

an increased frequency of sexual activity, a higher degree of sexual involvement, and lower rates of birth control use. Also, researchers have repeatedly found data illustrating an increased risk of revictimization for CSA survivors (Briere, 1988; Chu & Dill, 1990; Follette et al., 1996).

The use of the experiential avoidance construct is helpful in that it serves to explain the many diverse outcomes that can be associated with a history of abuse. Using this framework to understand psychological functioning has led to the development of acceptance-based therapeutic approaches that focus on letting go of the attempt to avoid or control thoughts and feelings. Instead of having the agenda of avoiding "bad" feelings and thoughts, the agenda involves observation of and openness to the client's experiences. Hayes (1994) stated that "as one gives up on trying to be different one becomes immediately different in a very profound way" (p. 20). This type of change is at the heart of treatment for survivors of sexual abuse; frequently the acceptance of the self is the most fundamental treatment goal. Many of our clients report prolonged efforts to get rid of their abuse histories, in essence to get rid of a part of themselves. The treatment goals for this therapy involve acceptance of the self and the adoption of a commitment to new behaviors that are consistent with client-identified life goals.

The implementation of a contextual approach does not mean other methods cannot be used. Rather, strategies that are more traditional, for example, cognitive or operant conditioning techniques, could still be useful if they serve as part of a coherent plan and are measured against the criterion of successful working.

Assessment

Behaviors (including thoughts and emotions) are considered as acts in context. That is, instead of analyzing specific incidents of behavior in isolation, situations are interpreted in terms of a larger experience, or context. Using such an approach, the focus on causality shifts to a focus on relations between events, thoughts, and actions. **With the focus on the act in context, no behavior in and of itself is right or wrong. Instead, the truth criterion shifts from right or wrong to successful or unsuccessful working.** For example, a contextual interpretation of self-injurious behaviors would be that the behaviors make sense given the person's history; however, these behaviors are no longer functioning to help meet the person's goals of having a life worth living (Linehan, 1993). This aspect of our conceptualization is important for a number of reasons, including the emphasis on a nonpejorative approach to trauma symptoms. **When conducting assessments of the client's complaints, the therapist should gather information about the survivor's history, current problems, and factors that may be maintaining those problems. The therapist should assess current problem behaviors and how those behaviors function for the client in her environment.**

One approach to this type of assessment is a clinical functional analysis. Naugle and Follette (1998) **provide a detailed description of functional analyses with trauma survivors.** Briefly, in the initial phases of treatment the clinician identifies the client's problems and the situations in which these problems occur. After gathering information about when these problems occur, and what happens before and after them, the therapist analyzes the information to find possible causal relationships. Further information should then be gathered and a treatment plan devised based on the analysis.

Functional analyses are useful in assessing problems and in guiding treatment because they help identify controlling variables in the client's life. Controlling variables precede or follow client behaviors and are related to the occurrence of the behaviors. A thorough assessment would pursue "if. . . , then. . ." relationships for behaviors and consequences in the client's life. For example, if she drinks alcohol, what happens? What types of situations typically precede her drinking? Follow her drinking? How does she feel while she is drinking?

Through functional analyses, clinicians can examine the relationship between clients' target behaviors, or symptoms, and the environment (Naugle & Follette, 1998). Functional analyses can be used to develop case conceptualizations and identify functional relations that guide treatment. For example, drug use may function as an escape from thoughts of being raped. With such analyses, the syndrome (for example, PTSD) is less the focus of therapy than the client's complaints and the functions of those complaints. Sur-

vivors present to therapists to address problems that have been developed and maintained by both recent and more distant events. Although it is important to understand historical and situational variables that influence the client's behavior, it is critical to focus on the client's current level of functioning (Follette et al., 1998). **Solely focusing on the content of historical events can be a serious risk in the treatment of survivors. Rather, the therapist should address behaviors in the current context which can be problematic when they no longer function to enhance the person's life. In fact, behavioral repertoires that some survivors develop in childhood can become punishing in their adult lives; for example, dissociation and distrust.** The focus on functional relations in the environment creates a nonblaming stance (Follette et al., 1998), in which the person's behaviors make sense given her history, and those behaviors that are not working effectively in the present context can be changed. The therapist and survivor can work collaboratively in the therapy setting to help the client enhance her quality of life.

Some of the domains suggested by Naugle and Follette (1998) as potential areas for investigation are addressed here (see Naugle & Follette, 1998, for a thorough review of the functional domains of trauma symptoms). The client may approach life with a rigid, rule-governed approach to problem solving that lacks sensitivity to environmental changes or differences. Another difficulty for some CSA survivors is the issue of behavioral deficits, for example, the lack of communication or emotion-labeling skills. **Assessment of deficits can be done in the context of role playing or having the client describe in detail how they would act and feel in different situations. If a client has a deficient repertoire in some area, then a target of treatment may be skills training. Behavioral excesses may also interfere with clients' daily functioning. High-risk sexual behavior and physical aggression are behavioral excesses that can lead to negative consequences for the client and others.**

As with all clinical populations, an assessment of suicidal ideation is essential. Even if there is no suicidal ideation at the beginning of treatment, repeated assessment of thoughts and urges related to suicide should be assessed as treatment progresses. For some CSA survivors, these thoughts will become more intense during exposure treatment. In their work with rape survivors, Foa and Rothbaum (1998) recommended assessing for suicidal and other self-injurious ideation within the context of discussing common reactions to abuse. The client and therapist should discuss the client's thoughts, urges, feelings, fantasies, and plans and means to harm herself. Linehan (1993) provides excellent guidelines for reducing both suicidal and parasuicidal behavior.

A thorough assessment of the client's presenting problems is important in order to create the most effective course of treatment for each individual. Reporting a history of CSA does not necessarily dictate one specific treatment strategy. Rather, **it is essential that the therapist evaluates the client's current complaints and address those problems. Such an approach is consistent with the need for time-limited psychotherapy that is a part of the managed care environment. The therapist and client should work together to identify and prioritize issues in developing an individualized treatment plan.**

Treatment Strategies

Cognitive-behavioral approaches to treatment have become increasingly popular because of their demonstrated efficacy in adressing a variety of psychological problems. Cognitive-behavioral methods are theory-driven and supported by empirical evidence from both basic and applied science. A thorough functional analysis will indicate appropriate targets for treatment. Strategies used to focus on some of those problems will be presented here. **Areas to be addressed include the therapeutic relationship, exposure therapy, anger, guilt, dissociation, and specific skills deficits.** This is not intended to be an exhaustive list of strategies but rather to exemplify some common approaches.

Therapeutic Relationship:

Some survivors of CSA have never discussed their abuse history with others, and many survivors actively avoid thinking about any events related to their abuse. **Therefore, it is essential that the therapist establishes a trusting relationship with the client before pursuing more in-depth phases of treatment. Creating a safe environment is axiomatic of any good therapy, but may be especially difficult for client's with a trauma**

history. Such clients are often very sensitive to others' cues and will quickly detect therapists' responses to them. For example, if the therapist shows some unwillingness to engage in the exposure experience, it could lead to the client abandoning treatment goals in order to protect herself and the therapist. Attending to relationship and safety issues may prevent later difficulties in treatment. Moreover, the therapy environment provides an opportunity for addressing a number of relationship issues in vivo.

The therapeutic relationship can be used as a tool to facilitate change (Kohlenberg & Tsai, 1991). **Therapy provides multiple opportunities for the therapist to model behavior and respond contingently to different behaviors.** The therapist can relay to the client his or her reactions to the client's narratives and behaviors within sessions. For example, the therapist can respond to an upsetting circumstance that the client describes and model identification and labeling of his or her own emotions. **The therapeutic relationship provides the perfect opportunity for the therapist to assess some of the clinically relevant behaviors that occur in session. The client may be engaging in behaviors that preclude her from receiving adequate social support. If the therapist notices such behaviors during session, he or she can identify those behaviors and describe for the client how the behaviors affect the therapist during the session.** The therapist and client can then discuss the interaction, how it is similar or different from the rest of her life, and alternative behaviors that she can practice.

Intrusion and Avoidance:

People who experience traumatic stressors often struggle with intrusive reminders of the traumatic event. These reminders may take the form of thoughts, emotions, dreams, flashbacks, and bodily sensations. Over time, other situations, people, or objects may also come to be associated with the trauma. Such intrusive symptoms invoke anxiety and fear in many clients. **It is important for the therapist to normalize these intrusive reactions to trauma and explain that these symptoms may become more frequent and intense during therapy.** The therapist can also explain that some CSA survivors report that these symptoms decrease over time, but the symptoms may recur periodically throughout her life.

A common response to the intrusions associated with abuse is avoidance. As an overlearned strategy, the avoidance will naturally occur in session as well as outside the treatment setting. Reasons for avoidance in therapy range from problems with trusting the therapist, difficulties breaking the pattern of avoidance behaviors, embarrassment, and shame. **The therapist works with the client to identify avoidance as the problem, working to demonstrate how this process may create even more problems for the client over time.**

Acceptance and commitment techniques (Hayes et al, 1999) **are useful in moving the focus of treatment from controlling flashbacks, thoughts, and bodily sensations to accepting them and changing the client's typical response to these experiences.** The dialectic of acceptance and change is at the core of the work across treatment domains. After the establishment of an effective working relationship and commitment to the goals of treatment, the exposure work can generally begin.

Exposure:

Central to the treatment of any trauma survivor experiencing recurrent intrusions is the idea that avoiding these private experiences leads to greater distress. The rationale for exposure is that confronting previously avoided experiences will provide an opportunity for the client to process the traumatic experience, which will lead to the dissipation of related symptoms (Foa & Rothbaum, 1998). Although avoidance may have some utility in the short-run, data suggest that it prolongs symptoms and can prevent recovery.

Many CSA survivors find the idea of reliving their abuse in therapy terrifying. Again, because this work is so difficult, it is important to establish rapport and commitment to treatment before exposure treatment begins. Therapists can address the client's hesitation by assuring her that the exposure of the feared thoughts, images, and situations will be done gradually, and the pace of therapy will be set collaboratively. For some clients, skills training in distress toler-

ance should precede any exposure treatment to avoid decompensation between sessions.

Exposure techniques require a fair amount of skill and practice. Before actually doing the treatment, the reader is encouraged to read more detailed descriptions of exposure, which are provided by Foa and Rothbaum (1998) **and Resick and Schnicke** (1993). During the first session, the therapist explains the rationale of exposure treatment and discusses concerns regarding the treatment. It is important that the therapist inform the client about what is involved in the treatment and assure the client that appropriate support is available for any crises between sessions.

At the beginning of each session, the therapist and client make an agenda that includes what the therapist would like to accomplish during the session and what the client would like to discuss. The therapist should describe the subjective units of distress (SUD) scale, which measures the distress the client reports on a scale of 0 (not distressed) to 100 (extremely distressed). The client will be asked to report these ratings throughout the treatment.

There are two forms of exposure treatment, imaginal and in vivo. **In imaginal exposure, the client recounts the details of her abuse in the present tense, including descriptions of emotional and physiological reactions that occurred during the abuse** (Foa & Rothbaum, 1998). The client should determine the level of detail she recounts in the first two sessions. She is encouraged to begin with a situation that arouses a low to moderate level of anxiety. After the first couple of sessions, the therapist should encourage the client to gradually add more detail about the situation, emotions, and physiological responses. The therapist will then ask the client to rate her anxiety level during and after each telling of her trauma. When a lower SUD level is reached, a different, slightly more arousing account should be described. The procedures are repeated until anxiety for all accounts is relatively low.

It is important that the therapist watches for avoidance behaviors that may interfere with the treatment. For example, drug or alcohol use are likely to make exposure techniques less effective. If the client is unwilling to fully participate in the exposure, then she will not be able to habituate to the distress that is associated with her memories. In addition, if the therapist does not fully attend to the client or avoids topics related to the abuse, then the client may not perceive the therapy room as a safe context in which to address her history.

Homework assignments may include asking the client to write portions of her abuse story in a journal and to read it several times during the week. Once the client can read through a particular narrative without experiencing significant distress, the client should write a different narrative. This procedure should continue until all of the client's accounts of her abuse have been written and SUD ratings are all low. Another way to encourage the client to do exposure at home is to tape record her narratives in session and have her listen to them at home. If homework is assigned, the client and therapist should decide in session what will be accomplished. Typically, the client is instructed to begin at a moderate level of anxiety and to be in the presence of that level for 30 to 45 seconds.

In vivo exposure involves encouraging the client to confront avoided situations that remind her of the abuse, such as being in an intimate relationship (Foa & Rothbaum, 1998). The client and therapist should generate a hierarchy of feared situations. Each situation should be assigned a SUD rating, and the client should successively confront each situation. During the course of in vivo exposure, the therapist should ascertain SUD ratings from the client. In vivo exposure can be done with the therapist or as a homework assignment.

Additional Treatment Domains

Although there is no one symptom or set of symptoms that is always associated with an abuse history, there are a number of issues that survivors report as more frequent problems (Polusny & Follette, 1995). This section introduces strategies to help clients with problems related to anger, guilt, shame, and dissociation.

Anger:

Along with feelings of loss and sorrow, some CSA survivors harbor a great deal of rage and anger. However, anger is often disguised by difficulties in expression, such as by being inhibited or misdirected toward the self. **Therefore, anger often appears in the therapy room as sarcasm, depression, judgmental comments, somatic complaints, anxiety, and attempts at manipulation** (Chemtob et al., 1997).

Anger may be a difficult emotion for the therapist to treat. **While it is important that the therapist not be defensive regarding anger, the therapist should express reasonable boundaries regarding the expression of that anger.** The balance for the therapist and client is to encourage expression of anger while not over-expressing rage. This balance may be achieved through relaxation skills and assertiveness training.

First, the client must be taught to discriminate anger from other feelings. The therapist can provide the client with information regarding anger and stress. In addition, the client should be asked to monitor triggers and to describe, in terms of thoughts, sensations, and behaviors, how she knows if she is getting angry. Relaxation or mindfulness exercises (which will be described later in this chapter) can be introduced as possible coping strategies to use when she starts feeling angry. Next, the client and therapist can role-play increasingly arousing situations while practicing assertiveness skills and relaxation. The client can also be taught skills to help her modify her cognitive appraisals and shift her attentional focus. For example, the client can practice empathizing with her enemies and considering alternative interpretations of events.

Often, anger is associated with unrealistic expectations of oneself and others (Novaco & Chemtob, 1998). **Clients may have poorly defined or unrealistic goals for therapy that may lead to frustration and anger if the desired effects do not occur immediately. The structure of therapy should be clearly explained to the client to avoid confusion and frustration.**

Guilt and Shame:

Kubany (1998) defined guilt as "an unpleasant feeling accompanied by a belief (or beliefs) that one should have thought, felt, or acted differently" (p. 126). **Many survivors ruminate over what they did and/or did not do that caused the abuse to occur.** They may also feel guilt for not being able to keep the abuser from molesting others or for experiencing sexual pleasure from the abuse. **These feelings of guilt often lead to shame and self-hatred** (Kubany, 1998). In addition, divulging family secrets, such as abusive environments, to the therapist may cause the client to feel a greater sense of guilt and shame.

The therapist can use a cognitive restructuring approach with these symptoms. First, the client and therapist should identify beliefs the client has about what they could have done to prevent the situation from occurring. Once these beliefs are identified, the therapist helps the client realize that hindsight knowledge is not useful to make decisions that were made in the past. Another strategy to address the client's guilt regarding the abuse is to have her list all the possible causal variables of the abuse and assign a percentage of responsibility each one had in the situation. The client and therapist can then critically reevaluate the variables' contribution to the event.

Many survivors experience guilt and shame for feeling aroused during abusive situations or for liking the attention. The therapist should try to normalize these feelings. It is important that the therapist responds to the client's disclosures in a validating and accepting manner. The act of disclosing, itself, is shameful for many women. The therapist should be careful to validate and reinforce disclosure, particularly early in treatment. **A central goal of treatment is to work with the client to trust, validate, and respect her own emotions, thoughts, and actions** (Linehan, 1993). For example, a therapist's response to a client's disclosure of her feelings concerning her abuse history could be similar to the following:

> "Your feelings of guilt, shame, anger . . . all of your feelings . . . make sense given what you have experienced. In fact, many women who have experienced similar histories report these same feelings. I know it may be difficult for you to describe these experiences and your feelings to me, and I think it is wonderful that you are letting yourself feel these emotions despite how uncomfortable they may be for you."

The therapist can also describe to the client his or her own emotional responses to the client's disclosures. The therapist's disclosures regarding his or her emotional responses serve the functions of validating the client's emotions and also modeling further emotion identification.

Dissociation:

Dissociation is a specific form of avoidance and numbing that some CSA survivors experience. Researchers have found that women with CSA histories are more highly dissociative than women with no abuse history (Farley & Keaney, 1997; Keaney & Farley, 1996). Before working on dissociative behaviors, it is useful to analyze what occurs before, during, and after these experiences; often, there are triggers that may lead clients into dissociative states. **Once these events are identified, the therapist should work with the client to identify when she is starting to dissociate by beginning with a chain of behaviors that lead to dissociation and replacing them with an opposing behavior.**

Since clients may dissociate during sessions, it is both useful and important to use those times to make the client aware of the specific behaviors she is engaging in at that moment. Having the client write down what she has learned and record between-session dissociative behaviors may also help the client remember skills and increase awareness of specific behaviors. **Some skills that the client can practice to replace dissociative behaviors could include relaxation techniques, mindfulness, and other stress-reduction strategies.**

If dissociation occurs during exposure exercises, the dissociative behaviors should gently be brought to the attention of the client. It is important that the client comes into contact with her anxiety during the exposure sessions. She cannot habituate to the painful thoughts and feelings if she does not allow herself to fully experience them. In addition, dissociation during psychotherapy could reinforce avoidance responses, cause the survivor to miss important therapeutic experiences, and interfere with learning emotion regulation (Briere, 1996).

Skills Deficits

Some survivors may need adjunctive treatment aimed at developing skills that facilitate the beneficial effects of exposure. Many women who have experienced intrafamial CSA grew up in invalidating parental environments. In such circumstances, caregivers are unsupportive and contradict the survivor's reported experiences. **Women who grew up in such families often experience difficulties labeling and expressing emotions, establishing meaningful relationships, and coping with distressing situations. It is beneficial to teach the client skills that could help them address these issues;** the reader is referred to Linehan (1993) for additional reading and handouts on these skills. Skill development should be introduced early and integrated into the continued treatment.

Mindfulness:

Mindfulness exercises can frequently be useful in the therapy session. These exercises can help focus the client and therapist as well as provide an opportunity to practice a coping strategy that can be used outside of session. **Clients often present to therapy trying to balance all of their struggles and daily life events. Therefore, clients are often distracted and have a hard time calming down and making themselves psychologically present. Mindfulness techniques help the client focus on her present experiences.** Other relaxation exercises may also function to help the client focus on the present context.

Mindfulness exercises may involve having the client get comfortable in her chair, close her eyes, and focus on her breathing. The client is then asked to notice various sensations; for example, her breath, her legs pressing against the chair, and tension in her body. Exercises typically proceed to having the client notice thoughts, memories, and emotions she is experiencing. She is instructed to experience exactly what is happening at the moment without avoiding or clinging to any of it (Linehan, 1993). The rationale is that with enough practice, the client will be able to have different thoughts, feelings, and memories throughout the day without focusing on any one experience and becoming distressed. Instead, the experiences will simply come and go. The reader is referred to Linehan (1993) and Hayes et al. (1999) for specific exercises that can be practiced.

Emotion Labeling:

One barrier to being open and accepting of feelings is the inability to properly label and discriminate different emotions. The inability to identify private experiences may interfere with the development of relationships (including the therapeutic relationship) and the experience of exposure work. Often, survivors describe one

emotion (i.e., anger) in response to all difficult situations. Discrimination training may be helpful for these clients. The therapist can work with the client to describe emotions in terms of physical sensations, facial expressions, and circumstances in which she would feel that emotion, its aftereffects, and how it differs from other emotions (Linehan, 1993). After she learns to observe and describe emotions, the client can begin work on labeling the described emotions.

Social Skills:

Many survivors of abuse experience difficulties in relationships with others. While some women avoid asserting their wants and needs, others may tend to be demanding and aggressive. Assertiveness training can be useful to these women with difficulty expressing their needs and to those who fall between these extremes. Increased communication skills may provide a sense of empowerment, since these skills will help the client be more effective in getting her needs met while developing and maintaining social support. **It is important that clients have support outside of therapy to help maintain and generalize treatment effects.**

The therapist can ask the client to role-play and practice social situations during the therapy session. When the client practices effective social skills, the therapist should reinforce those behaviors. When ineffective skills are used, the therapist should point out those specific behaviors and brainstorm with the client to identify more effective strategies that would achieve the desired outcome. In addition, the therapist should provide feedback regarding natural communications that occur between the therapist and client during the session.

Current Issues

Recovered Memory:

One issue that has evoked a great deal of debate in therapy rooms and courtrooms is the existence and veracity of recovered memories. In 1996, the American Psychological Association (APA) Working Group on the Investigation of Memories of Childhood Abuse issued a report describing research and arguments both for and against the significance of this phenomenon. Despite historical analyses and empirical investigations, few definite conclusions were made. Rather, points of agreement and disagreement were outlined and explained. Few definitive guidelines were offered to practicing clinicians. This result demonstrates that social and political values color interpretations of empirical and clinical evidence regarding child sexual abuse. Few other mental health conditions have sparked the debate that trauma-induced psychological disturbances have.

Some points of agreement in the APA Working Group on the Investigation of Memories of Childhood Abuse Final Report (1996) were that child sexual abuse is a complex and pervasive problem that has historically gone unacknowledged. In addition, they explained that while it is possible for memories of abuse that have been forgotten for a long time to be remembered, it is also possible to form convincing pseudomemories for events that never occurred.

Palm and Gibson (1998) outlined guidelines clinicians can follow in order to provide ethical treatment of CSA clients:

1. **Therapists should not stray from their areas of competence.**
2. **Therapists need to stay informed regarding the recovered memory debate**
3. **Therapists need to understand that sexual abuse is part of our cultural context**
4. **Psychologists need to remember that memory is fallible, and it is crucial that issues addressed in therapy are truly those of the client.**
5. **Although many clinicians . . . [do] not believe the accuracy of memories is necessarily important for therapy, clinicians may be forced to attend to the accuracy question in the case of litigation . . . [and therefore] . . . it may be best for the therapist to avoid memory enhancement techniques. (p. 260).**

Pope and Brown (1996) suggested that therapists do careful assessment of the client's and their own behavior in recovered memory cases. They stressed that it is important to minimize power imbalances and to let the

client set her own pace. **Memory recovery should not be the goal of therapy.** Focusing on memory recovery conflicts with the goals of therapy that have a contextual approach. Memory recovery focuses on content versus context, and the past as opposed to the past as it relates to the present. Therefore, not only does that goal of memory recovery create a risk for the possible creation of false memories, but also this goal is contrary to a contextual approach to therapy in general. **Therapists should discuss the phenomenon of memory suggestion in a validating manner with the client. It should be emphasized that if the client does not remember specific details of the abuse, she does not have to make herself try to remember.** Often, if there is something else that the client cannot recall at a specific time, she will recall it at a later date.

Conclusion

Cognitive-behavioral techniques for trauma survivors have been based on theoretically and empirically supported principles. Exposure treatment was developed to help reintroduce previously avoided events in a systematic manner. Although exposure has been shown to be effective for many individuals (Boudewyns & Hyer, 1990; Foa, et al., 1991; Keane, et al., 1985), it is important to adequately assess clients' symptoms to determine if the complaints are related to a CSA history and if the client has the skills to proceed with the treatment if it is warranted. Additional techniques that were described in this lesson included role-playing, modeling, skills training, and cognitive restructuring. Given that many therapists are constrained by time-limited psychotherapy, it is important that the therapist conducts a careful assessment of the client's problems so that the most clinically important issues can be identified and treated.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

25. Experimental avoidance has been defined as the "unwillingness to experience unpleasant internal events such as thoughts and feelings associated with the abuse." This avoidance can take which of the following forms for clients:

A. Substance abuse.

B. Self-injurious behaviors.

C. Dissociation.

D. All of the above

26. It is important to conduct a clinical functional analysis in order to:

A. Give the client a chance to be heard.

B. Understand a client's symptoms and environment, and also to develop treatment that is tailored to the client's particular symptoms and problem behaviors.

C. Identify which DSM diagnostic criteria the client meets.

D. Ensure that the client reports her history accurately and consistently.

27. When providing treatment to a client who thinks she may have been sexually abused as a child, but is not certain that she was, the clinician should:

A. Use memory enhancement techniques.

B. Explain to the client that the abuse most likely did not occur.

C. Discuss the phenomenon of memory suggestion in a validating manner and emphasize that she does not have to make herself remember in order to make progress in therapy.

D. Tell the client that she is uncertain because she still fears her perpetrator.

28. The current rationale for exposure treatment for CSA survivors is:

A. Exposure provides the opportunity for the client to process the traumatic experience and become habituated to the anxiety it causes, which will lead to the dissipation of related symptoms

B. Exposure provides the opportunity for conflict resolution between the id and the superego

C. Exposure enables the client to feel relaxed during the treatment

D. Exposure helps the client to recall important specific details of the abuse which are crucial for therapy to be effective

DIRECTIONS
Volume 11 Lesson 8

Identifying and Treating Body Dysmorphic Disorder

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Introduction

Imagine the following scenario: You awaken in the morning and find that you have a large crease across your face from the way you were sleeping on your pillow. It is quite visible to the naked eye, a bit red and irritated, and runs from your eyebrow down to your chin. Even after showering and preparing for the day, the crease is still apparent, although faint. The question now is, will you be comfortable going to work on that day? Extend this further and imagine that the crease is permanent. Do you go to work? What will be your level of comfort around friends and family, especially those who haven't seen you for some time? What if your doctor tells you that there is nothing to be done, that your skin is going to remain in this damaged state?

This problem appears rather remote (since we rarely damage ourselves on our pillows while asleep). However, individuals who suffer from Body Dysmorphic Disorder (BDD) struggle with a similar problem, but for them it is an unremitting, daily intrusion. What compounds the difficulty is that other people do not see the problem. The only one who perceives the physical defect is the BDD sufferer; and to the BDD sufferer the defect is catastrophic.

As yet, there is virtually no prevalence data available regarding BDD. While it has been assumed to be fairly rare, the prevalence is difficult to determine since BDD patients rarely and spontaneously seek therapy, and are unlikely to spontaneously report their symptoms. There have been some suggestions that the prevalence rate is higher than suspected since BDD patients are more likely to seek treatment from other medical service providers, operating from the assumption that their defects are purely medical in origin and not related to mental health. For example, many BDD sufferers are utilization burdens for cosmetic surgeons, dermatologists, and general care practitioners. There has been

some demographic data that describes age of onset, with estimates being in early to mid-adolescence (Phillips, et al., 1994). Further, BDD typically is associated with a complex clinical picture, generally presenting with multiple comorbidities of Axis I disorders (Phillips & Diaz, 1997) and Axis II disorders (Neziroglu et al., 1996). Among Axis I disorders, mood and anxiety disorders were among the most frequently comorbid diagnoses. Among Axis II disorders, there was no discernible unifying trend.

The objectives of this lesson are to (1) familiarize readers with the nature of BDD, (2) establish a basic understanding of how to distinguish BDD from other psychological disturbances, (3) identify some major theoretical perspectives on the etiology of BDD, and (4) describe the basic format for engaging in both behavioral therapy (via exposure with response prevention) and cognitive therapy.

Background and Definitions

Although it has been known to psychopathologists for quite some time, and has benefited from a recent flurry of research investigation, BDD is still a poorly understood condition. **Originally known as dysmorphophobia** (Morselli, 1891), the characteristics and definition of the condition have remained essentially unchanged. That is, **the sufferer experiences a preoccupation** (obsession) **with a particular body part or parts and usually believes that the area(s) is defective or imperfect.** Recent research has focused on the relationship that BDD has with Obsessive-Compulsive Disorder (OCD) (Goldsmith et al., 1998; McKay, Neziroglu, et al., 1997). In particular, **BDD has recently been considered a part of a group of disorders collectively referred to as *obsessive-compulsive spectrum disorders*. These disorders share the feature of being obsessive in nature and have rituals associated with them.**

Briefly, **OCD is a condition characterized by repetitive and unwanted thoughts that may lead to compulsive behaviors intended to alleviate or neutralize those thoughts.** Stereotypically, compulsive washing comes to mind, where the cleansing rids the sufferer of thoughts associated with dirt and germs. Likewise, checking rituals alleviate thoughts that a behavior was not completed, or was completed improperly. For BDD, there also exist unwanted thoughts and ritualized behavior. For example, the unwanted thought that someone might notice a facial blemish may result in an elaborate and complex mirror checking ritual to alleviate that thought.

Relationship to OCD:

Recent research appears to support the inclusion of BDD in the obsessive spectrum on the basis of several features. First, **BDD patients' levels of obsession about their perceived defect are similar to that of OCD patients' about their target obsessions, and they have similar levels of trait anxiety** (McKay, Neziroglu, et al., 1997). Second, **individuals with BDD and OCD respond similarly to psychotropic medications such as selective-serotonin reuptake inhibitors** (Phillips, 1996). Finally, **these groups respond in a similar fashion to cognitive behavioral therapy when the therapy is structured in the same way, such as with exposure with response prevention** (ERP; McKay, Todaro, et al., 1997; McKay, 1999; Neziroglu & Yaryura-Tobias, 1993).

Despite these similarities, there are many noteworthy differences. **In the one study that directly compared BDD with OCD on a variety of assessment measures, it was found that the group levels were similar in terms of obsession and compulsion, but differed in terms of depression and overvalued ideas, which were both assessed at higher levels in BDD** (McKay, Neziroglu, et al., 1997). Overvalued ideas are thoughts and/or behaviors, or patterns of thought and/or behaviors, with very high levels of conviction, and that are associated with either the obsessive idea or the necessity of carrying out a compulsion. As levels of conviction for overvalued ideas increase, treatment outcome has been hypothesized to be poorer (Foa, 1979; Kozak & Foa, 1994). This point will be considered again later in the discussion of therapeutic strategies.

Theoretical and Etiological Features

Although there have been descriptive accounts of BDD for many years, theoretical accounts of the etiology are more recent. Classical psychodynamic theorists viewed dysmorphophobia as either primary obsessional neurosis (Fenichel, 1945) or, more likely, as a narcissistic reac-

tion based upon some interpersonal rejection. Because the primary narcissistic patient would not be able to integrate interpersonal rejection into ego defenses, it is hypothesized that the BDD sufferer retreats into self-scrutiny that centers on a circumscribed physical feature, even one without any apparent defect.

Research examining the possible effectiveness of medication in the treatment of BDD has demonstrated that this condition is associated with defects in the serotonergic system. **Several published reports show that selective-serotonin reuptake inhibitors are effective in alleviating BDD symptoms, but that augmentation strategies** (such as inclusion of Lithium or antipsychotic medications) **are frequently necessary** (Phillips, 2000). It should be noted that the research in this area is all fairly recent, and there are as yet no published double-blind trials in the treatment of BDD. However, if this is indeed a point of connection between OCD and BDD, then a whole host of other neuropsychiatric similarities are likely, such as frontal lobe dysfunction and nonverbal memory impairment (Rauch & Savage, 2000).

Cognitive-behavioral perspectives on BDD support a learning-based etiology in which primary BDD may develop after a series of events that cause the sufferer to experience negative reactions to isolated physical features in conjunction with negative affect (Neziroglu, Yaryura-Tobias, et al., 1999). However, the currently accepted perspective is that the BDD sufferer experiences disruptive negative thoughts which contribute to the perception that the specified body area is defective. **In keeping with the experimental cognitive view** (Williams et al., 1997), **it is suggested that individuals with BDD are attuned to environmental cues ambiguously related to perceptions of bodily defects,** creating a propensity toward self-scrutiny in order to diminish the perceived likelihood of negative evaluation. **There are an impressive number of environmental cues that could trigger body dysmorphic concerns.** For example, approaching a soda case in a delicatessen, where there is a large panel glass that is body length, offers a reflection of the person and highlights possible dysmorphic concerns. Likewise, passing by a storefront window offers a cue for dysmorphic reactions. These perceptions lead to the BDD sufferer's increased need to be reassured that their appearance is perfect, to enact rituals related to hygiene, and to avoid stimuli perceived to be detrimental to appearance. For example, if skin complexion is the primary concern, the BDD sufferer may go to great lengths to avoid not only ingesting fried foods, but touching areas that had been in contact with fried foods out of concern that they will then touch their face and break out.

Assessment of Acute and Ancillary Symptoms:

Individuals with BDD experience extreme anxiety and depression. Although not significantly different from individuals with OCD, the level of anxiety and depression experienced among people with BDD is in the clinically severe range (McKay, Neziroglu, et al., 1997). Indeed, although it was not examined in the comparison study with OCD, other researchers have found that BDD is associated with significant occupational impairment and increased risk of suicide (Phillips et al., 1994). **This makes it all the more important to clearly identify levels of suicide ideation and intent among BDD sufferers.**

BDD is also associated with greater levels of characterological problems. BDD is a member of the broader class of somatoform disorders; Eysenck (1982) has observed that these disorders are higher-order anxiety disorders, usually associated with long-standing personality characteristics that contribute to the continuation of the condition. Although Eysenck's assertions were largely theoretical, recent investigations support his position. Specifically, it has been found that individuals with BDD have significantly higher levels of personality disturbance than those with OCD (Neziroglu et al., 1996; McKay, Todaro et al., 1996). Collectively, this speaks to the recalcitrant nature of BDD and how it presents a special challenge for clinicians to provide effective treatment to this population.

Overvalued Ideas:

Recently, overvalued ideation has come to be considered to be specific to obsessive-compulsive–related disorders in which the patient feels that their belief in the obsessive idea is reasonable. This is in contrast with traditional conceptualizations of obsessive disorders in which the sufferer views the symptoms as unreasonable, but uncontrollable. A recent scale has been shown to

validly measure the overall level of conviction of the overvalued ideas (Neziroglu et al., 1999). **A recent study has shown that the level of conviction of the overvalued ideas is associated with treatment outcome for the obsessive aspects of BDD, but not for the compulsive aspects of BDD. In short, as the level of conviction of the overvalued ideas increase for the sufferers dysmorphic concerns,** treatment outcome is likely to be poorer (Neziroglu et al., in press). This finding suggests that the functional component of BDD is obsessive and that the compulsive behaviors are akin to residual symptoms from the obsessions.

Making the Diagnosis: Rule-Out Diagnoses

BDD is difficult to diagnose, largely because there are several other syndromes with similar symptoms or phenomenology, but there are several issues to consider which may aid in this process. First, **BDD is associated with excessive concern with a specific body part or parts. Typical physical concerns are complexion, eye shape, symmetry of body parts (i.e., right and left nostril), or size of body parts** (such as the perception that the legs or arms are too long), to name a few. Second, BDD is not a plausible diagnosis if the individual has an eating disorder. **A diagnosis of BDD is easier to ascertain once it is established that an eating disorder does not exist. Individuals with eating disorders are typically dysmorphic about areas or attributes such as the stomach, buttocks, or leg girth, which commonly rule out BDD.** Finally, BDD is not typically associated with psychosis, which might be more closely associated with monosymptomatic hypochondriasis. This may be the most difficult aspect of differential diagnosis for BDD, as most BDD sufferers present with strong conviction regarding their perceived physical defects. One way to approach this problem is by inquiring carefully about the perception others have regarding the potential BDD sufferer's perceived defect, and whether there are times when the BDD sufferer feels that the defect is better than at other times. Whereas individuals with monosymptomatic hypochondriasis are likely to maintain their conviction across situations and time, individuals with BDD typically show some fluctuation.

Treatment

Pharmacotherapy:

A recent spate of research has shown that BDD is responsive to the popular class of antidepressants collectively referred to as selective-serotonin reuptake inhibitors (SSRIs). For example, Phillips et al (1994) showed that over 50% of patients prescribed SSRIs were moderately to markedly improved. However, there have not yet been any controlled trials for a single SSRI in BDD. Instead, a body of literature has begun to emerge that supports using SSRIs in combination with other classes of medication, either antianxiety agents or, in some cases, antipsychotic medication (Phillips, 1998). It should be noted that on the one hand, very little sound clinical outcome data regarding BDD have been obtained to support particular medications or classes of medications. On the other hand, most BDD sufferers, when engaged in treatment, seek medication and report improvement as a result of these agents. In consultation with psychiatrists, this author has found that BDD patients respond best to initial trials of SSRIs, with augmentation strategies used only after a period of either nonresponse or a plateau of response while still functioning poorly.

Behavioral and Cognitive Treatment:

Behavior Therapy

Developments in the psyhosocial treatment of BDD have closely mirrored those of OCD. Specifically, most

Table 1

DSM-IV DIAGNOSTIC CRITERIA FOR BODY DYSMORPHIC DISORDER

- Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concerns is markedly excessive.
- The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of function.
- The preoccupation is not better accounted for by another mental disorder (e.g., dissatisfaction with body shape and size in Anorexia Nervosa).

of the behavioral interventions aimed at alleviating BDD have conceptualized the problem as a set of anxiety-reducing rituals that surround an obsessive idea. Therefore, it is theorized that if treatment can reduce the compulsive behaviors, the obsessive ideas should begin to remit. Accordingly, **purely behavioral interventions for BDD have typically resembled ERP, which is a mainstay intervention in the treatment of OCD** (Foa et al., 1998). Investigations into the utility of ERP as a treatment for BDD have been encouraging, but should be tempered by acknowledging the necessity of treatment with longer sessions and shorter time between sessions than for OCD. For example, it would not be uncommon to require ninety-minute sessions to adequately treat a patient with BDD. In more extreme cases, hospitalization with daily 90-minute sessions would be warranted. In a recent study examining the predictive value of overvalued ideas in determining treatment outcome in BDD, the entire sample had symptoms sufficiently severe to require inpatient care, typically for a one-month period (Neziroglu et al., in press). This was likewise the case in the two treatment series depicting a maintenance program for BDD after a period of intensive behavioral therapy (McKay, Todaro et al., 1997; McKay, 1999).

Typically, **hospitalization is warranted under circumstances in which the symptoms of BDD are too severe to allow successful completion of behavior therapy exercises during sessions, and/or when the individual's mobility is impaired.** For example, in some cases, symptoms of BDD become so great that the sufferer cannot leave home for any appreciable period of time, or may only go out during certain times of day. One case that was seen by this author involved a woman who could only go out at night or on rainy days due to a belief that sunlight would adversely affect her complexion. Her symptoms were so severe that even certain indoor lighting produced great fear and avoidance.

Treatment using ERP is not for the faint of heart—it can be challenging for client and therapist. Interventions of this sort require direct modification of rituals, typically best rendered under in vivo conditions. That is, exercises must usually take place live, in the client's natural environment (or something that closely approximates the client's natural environment).

Case Example:

Let's consider an illustrative scenario: I recently treated a 31-year-old woman (pseudonym: Darla) who had symptoms of BDD for more than 10 years. She was primarily concerned with the shape of her eyes, specifically that they were not symmetrical. She would spend more than two hours per day trying to apply makeup and shadow to minimize the perceived asymmetry, and then would seek reassurance and confirmation from her boyfriend that her eyes appeared symmetrical. She believed that the asymmetry detracted from her desirability, and she could not tolerate the thought that others would observe her and note that here eyes were asymmetrical. This was not her only BDD symptom, but it will be the focal point as it illustrates well the ERP approach to treatment.

Part I—Prepping the Client

ERP induces anxiety as a means of producing habituation to the feared consequences that the rituals are perceived to prevent. Therefore, in the long-term, **anxiety is reduced by repeated exposure to the fear-producing stimuli.** The treatment the clinician proposes to the client will evoke considerable anxiety during the session; the problem facing the clinician is how to get the client to engage in these activities. Convincing the client of the benefits of ERP requires educating them regarding the necessity of the activity to ultimately reduce the fear, and providing reassurance that the exposure will be paced at a tolerable level. Usually, the clinician must construct with the patient a hierarchy of feared situations to comfortably reduce the fear. That is, by following the hierarchy, one can engage in therapeutic exercises that are paced in a way that the patient can tolerate, becoming increasingly challenging as each successive step is mastered. In more advanced sessions, however, especially for BDD, ERP requires engaging in activities during which the client must endure feeling that the perceived defect is noticed by everyone.

Part II–Climbing the Hierarchy

Let's return to our illustration with Darla. Her primary concern described here was perceived asymmetry of her eyes. As a first step in ERP, we constructed a hierarchy as shown in Table 2.

Table 2
SAMPLE HIERARCHY—DYSMORPHIA REGARDING SYMMETRY OF EYES

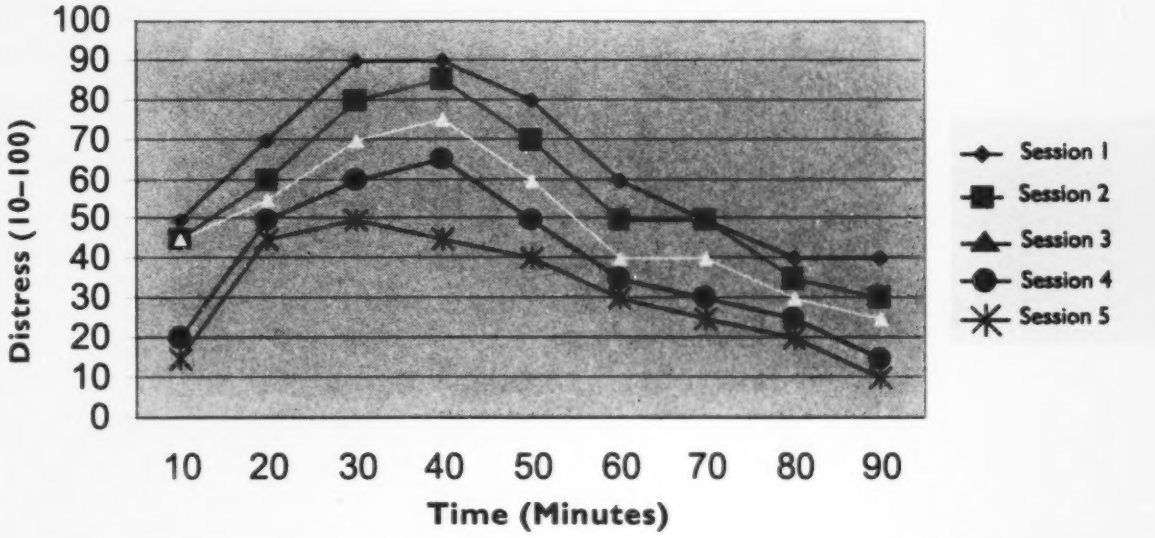
Distress Rating (0–100)	Appearance
10	Several eyelashes on one eye uneven
20	Eye shadow slightly smudged on one eye
30	Eye shadow smudged on one eye and several eyelashes uneven
40	Eye shadow slightly smudged on both eyes
50	Eye shadow incompletely applied to one eye
60	Eye shadow smudged and incompletely applied to one eye and eyelashes uneven
70	Eye shadow visibly missing from spots on one eye
80	Eye shadow completely missing from one eye, and poorly applied to other eye
90	Mismatch in color and density of eye shadow on one eye, and an eyelash is lying on cheek
100	Eyes mismatch drastically in eye shadow, and several eyelashes are on cheek

We discussed the merits of ERP, and how her current method of managing her anxiety was creating problems in her life, both emotionally and interpersonally. In this regard the therapist's role is similar to that of a salesperson—the client needs to be "sold" on the idea that the therapeutic pain and anxiety is a better deal in the long run than the current situation of avoidance and constant need for reassurance.

In Darla's case, once treatment began in earnest, we moved rapidly up the hierarchy. Sessions were long (90 minutes) and frequent (three times per week). Most of the time was devoted to engaging in ERP and ensuring that her anxiety decreased by the end of the session. Between sessions, she was given homework that was designed to encourage greater treatment gains, usually in the same format as that adopted during sessions. For example, one session was spent applying makeup imperfectly and then going out in public. To ensure that the imperfect makeup application was seen by others, we went to stores to request sales assistance; Darla was instructed to make and maintain eye contact, ask for clarification, and then disengage from the social interaction. Later, we spent sessions in which she applied makeup markedly wrong (i.e., to accentuate her asymmetry, such as applying a different color of eye shadow to each eye) and would then again go out in public. As a culmination, she applied makeup carelessly and then went to dinner with her boyfriend. As part of treatment, her boyfriend was instructed to avoid providing reassurance, instead informing her that her eyes were clearly asymmetrical. Homework assignments given to Darla to challenge these concerns included applying makeup without a mirror, going out and making eye contact with at least three people when she felt her makeup was applied incorrectly, and avoiding mirrors as a means of checking her appearance.

A question that might arise at this point is why the lengthier session is necessary. A tenet of any anxiety-inducing treatment maintains that clients must not leave the session more anxious than when they arrived. If this occurs, the client will be fearful of therapy as well as the target phobic stimuli. As part of the educational preparation before initiating treatment, it is important to emphasize this aspect of treatment. It is not uncommon to recommend that a client remain in the office waiting room until the anxiety dissipates. Figure 1 shows a pattern of anxiety increase and decrease within sessions for Darla. While challenging, it is not recommended that other anxiety reduction strategies be employed during ERP. This is due to the theoretical mechanism of action during ERP, namely habituation of fear. **Applying relaxation or breathing retraining skills would actually serve a counter-productive role in this treatment as the client would apply these during periods where the most clinically salient effects would come about due to exposure.** Clinical observations also suggest that during periods of particularly high anxiety, clients are not able to apply alternate anxiety reduction strategies as the anxiety is primarily cognitive, not physiological.

Figure 1
ANXIETY DECAY DURING EXPOSURE WITH RESPONSE PREVENTION WITHIN AND BETWEEN SESSIONS: DARLA ILLUSTRATION



Part III—Cognitive Therapy

Currently, there are a number of variants of cognitive therapy, the method referred to in this case most closely follows the format described by Beck and colleagues. This cognitive therapy model has been applied to anxiety disorders (Beck et al., 1985) and has been most often modified for treating BDD. **In the case of BDD, as with all anxiety disorders, it is important that the emphasis of cognitive therapy be primarily upon the distorted cognitions that raise concerns over the consequences of the body dysmorphia, and not simply provide self-directed reassurance.** Cognitive therapy must focus upon the thoughts that lead to the emotional state (i.e. the feeling that they must be perfect or not appear anxious). Thus, **when a client articulates concern about having asymmetrical eyes, asking for evidence that having asymmetrical eyes is bad may not be a productive strategy.** This is not unlike reassurances that may be offered by well-intentioned family and friends; although the questions and reassurance are meant to focus on the unreasonableness of the overvalued idea, they provide a means for additional avoidance and likely continued obsessive behavior surrounding the perceived physical defect. For this reason, inquiring about the consequences of being noticed as imperfect or of being anxious in public does not serve a treatment purpose. **Most BDD patients are concerned that others will notice their flaws; they are anxious that others will evaluate a minor physical imperfection as a global indication about themselves** (such as they are unattractive, undesirable, or not interpersonally appealing). It is the cognitions related to the importance of physical appearance and situational performance which should be questioned.

The following is a brief sample of a cognitive intervention used with Darla for her BDD concerns:

Therapist (T): *Darla, I recall that we were last speaking about how it is important for you to feel that others believe you appear perfect in all respects.*

Darla (D): *Yes, I still can't help feeling that I must appear perfect, not only physically, but socially.*

T: *Let's consider how likely it is that we can possibly be perfect in so many situations.*

D: *Okay.*

T: *Who do you know that you feel achieves your 'ideal' for perfection in so many situations and in physical appearance?*

D: *(Client names a well-known actress).*

T: *Okay. Now isn't she the one who gave a speech at an award show, and stuttered several lines?*

D: *(slowly) Yes.*

T: *Was she perfect then?*

D: *It does not seem that she was.*

T: *How can we explain this phenomenon, then, if she has achieved a perfect ideal?*

D: *Well, I guess she could have had a bad evening. But when I have a bad evening, it seems that I follow that with many more bad evenings, and days.*

T: *Do you recall when we discussed how we contribute to feeling bad following a less-than-ideal evening, and create additional poor situations?*

D: *Yes. After a bad evening, I feel like I totally blew it, and then the next time I put so much pressure on myself that I have trouble performing at all. We discussed how this is similar to viewing the problem as a catastrophe, rather than merely a bad moment that we would have preferred to work out more favorably.*

This brief interaction illustrates how the client may be reminded that attributing negative qualities to themselves after a poor performance can result in ongoing distress and additional poor interpersonal performances. In the case of BDD, it is often important to use others as a reference point, since many BDD clients spontaneously use others as references for their own appearance and actions. It is important to note that this session occurred after many sessions of ERP in which Darla had achieved considerable relief from her acute symptoms of BDD. Also, Darla was familiarized with some of the basic principles of cognitive therapy; she was acting as her own scientist, and therapy was used as a means to learn how to best manage situations in her own daily life. This includes critically questioning the conclusions that she reaches about her own behavior and reactions, and whether and how she can tolerate later imperfections.

Conclusion

BDD is a challenging condition to treat. The intention of this lesson has been to familiarize readers with diagnosis and procedures involved with treatment. The research on this condition is not yet well developed, but, so far, cognitive and behavioral treatments have shown promise in alleviating the distress associated with this disorder.

Appendix

Appendix I
PRINT AND WEB-BASED RESOURCES FOR BDD

*Note that there are few resources that directly address treatment for BDD. Instead, most of the information is either part of material related to OCD (such as individual chapters in books) or is related by virtue of similarities in the conditions of OCD and BDD.

Web-Based

Anxiety Disorders Association of America
http://www.adaa.org

Obsessive-Compulsive Foundation
http://www.pages.prodigy.com/alwillen/ocf.html

Expert consensus treatment guidelines for OCD
http://www.psychguides.com/eks_ocgl.htm

Professional Textbooks

Goodman,W.K.,Rudorfer,M.V.,& Maser,J.D.(2000). *Obsessive-Compulsive Disorder: Contemporary Issues in Treatment.* Mahwah,NJ:Erlbaum.(especially chapters 1,2,& 13).

Jenike,M.A.,Baer,L.,& Minichiello,W.E. (1998). *Obsessive-Compulsive Disorder:Practical Management* (3rd ed). St.Louis,MO:Mosby.(especially chapter 10).

Swinson,R.P.,Antony,M.M.,Rachman,S.,& Richter,M.A.(1998). *Obsessive-Compulsive Disorder: Theory,Research,and Treatment.*New York:Guilford.(especially chapters 17 & 18).

Client Resources

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

29. Which one of the following disorders rules out a diagnosis of BDD?

A. Major Depressive Disorder

B. Bulimia Nervosa

C. Hypochondriasis

D. Panic Disorder with Agoraphobia

30. Body Dysmorphic Disorder has recently been included in a group of disorders referred to as:

A. Personality Disorders.

B. Somatoform Disorders.

C. Anxiety Disorders.

D. Obsessive-Compulsive Spectrum Disorders.

31. Which psychosocial treatment has been most closely examined in research on therapy for BDD?

A. Exposure with Response Prevention

B. Brief Psychodynamic Therapy

C. Cognitive Therapy

D. Gestalt Therapy

32. Body Dysmorphic Disorder differs from Obsessive-Compulsive Disorder in that BDD is associated with:

A. Lower depression.

B. Higher anxiety.

C. Higher intensity of overvalued ideas.

D. Lower compulsivity.

DIRECTIONS
Volume 11 Lesson 9

Masochistic Phenomena Reconceptualized as a Response to Trauma: Recovery and Treatment

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Introduction

A great and varied amount of human behavior falls under the rubric of masochism. Though not all survivors of trauma are masochists, psychological trauma can push people in a masochistic direction, involving significant personality change, distortion of will, and fragmentation of self. This can involve lasting psychic damage—which then merits clinical attention. Despite potential over-inclusiveness, the word, "masochism," has been used meaningfully to describe a certain aspect of human experience, specifically psychological damage and revictimization. The vast literature on the topic has sought to explain why certain people seem to be damaged continuously, and often even appear to bring this damage upon themselves, willfully. Like the literature on the topic, the human suffering attributable to masochism is considerable. Masochism is such a pervasive construct in the mental health field and so prevalent in clinical actuality, that it is highly important that we name it and understand it.

If masochism is considered in relationship to trauma, it can be viewed as dissociation-based behavior that protects attachment need. Understood in this way, the victim-blaming connotations have no basis and will hopefully fade with time. In its protection of attachment need, masochism safeguards a kind of "hope for hope" (Howell, 1997b) that enhances the potential for recovery or regeneration (Westburg, 1997). Masochistic tendencies are understood as having been adaptive for the situations from which they emerged; yet the best adaptation for patients is to remove themselves from damaging situations whenever possible and to learn more self-enhancing behaviors.

This lesson will explore some of the traditional explanations of masochism (primarily involving the notion of an unconscious wish for suffering), **offer a reconceptualization of many masochistic phenomena as a response to**

trauma, emphasize that masochism is not a desire to suffer (though it may appear so on the surface), and will discuss guidelines for treating masochism. After studying this lesson the reader should have greater awareness of the trauma-based etiology of masochism and will be able to use this understanding in their conduct of treatment.

Masochism: Definition and Historical Context

Much of the literature on masochism, old as well as relatively new, has emphasized the presence of tendencies toward helplessness, revictimization, and self-blame. (Freud, 1924; Horney, 1937; Shainess, 1970; Menaker, 1979). **Masochism may be most usefully defined simply in terms of observed behavior, including the above signs and symptoms, as indicating a marked tendency to suffer abuse or pain from oneself or others.** Inferred motivation should be left out of the definition.

Masochism is not listed in the current *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) as a diagnostic category (American Psychiatric Association, 1994). Because masochism has more generally been understood in terms of a motivational rather than a behavioral construct, there has been a potential for misuse inherent in the term, the potential to blame a person who has been harmed for the harm done. For instance, a battered spouse, who may or may not be masochistic, might be labeled as such, and, on the basis of that diagnosis, she may be blamed for her abuse. It should be noted that the literature on battering indicates just the opposite of this assumption: the personality characteristics of the abusive partner are much more predictive of a woman's chances of being battered than are any of her own. (Brown, 1993, p.1,079). Or a rape victim might be blamed on the basis of her "wanting it" because of her supposed masochism (Caplan, 1985). In the DSM-III-R (APA, 1987), there was an attempt to deal with this problem by changing the name to Self-Defeating Personality Disorder and treating the diagnosis tentatively by placing it in the Appendix. This was an improvement, in that the intent was to use behaviorally-based criteria. However, the removal of the diagnosis from the subsequent

DSM-IV left a vast amount of human suffering unnamed, conveying nonrecognition of a real problem. **The voluminous literature on the topic of masochism indicates the importance of understanding the tendencies toward revictimization and self-destructiveness that are frequent sequellae of psychological trauma.**

Let us return to the origin of the term. It was first defined around the turn of the century by Dr. Richard von Krafft-Ebing, as "the wish to suffer pain and be subjected to force" (Caplan, 1985, p.19). Krafft-Ebing derived the term from the work of Leopold van Sacher-Masoch, especially Venus in Furs. Ironically, this novella portrayed a caricature of dominance and submission in a heterosexual relationship in which the submissive partner was male. (Caplan, 1985). While Freud felt that either men or women could be masochists, he and some of his followers viewed masochism as an aspect of "feminine nature" (Wimpfheimer & Schafer, 1979). It was Freud's dynamic formulation of masochism, which made the term a common element in modern vocabulary. Freud (1919, 1924) emphasized the "pleasure in the pain" of masochism and related masochism to an unconscious, sexualized wish to be beaten. **He named three categories of masochism** (1924)**: erotogenic masochism, feminine masochism, and moral masochism.** The most frequently discussed of these, moral masochism, emphasized the dynamic interplay between ego and superego whereby unconscious guilt feelings spur the pursuit of suffering or pain to appease the superego. Freud also viewed masochism as motivated by the death instinct, Thanatos (1920). Subsequent mental health literature broadened the hypothesized causes of masochism, giving attention to such matters as cultural and interpersonal issues (Horney, 1937), preoedipal (developmentally earlier than superego) issues (Menaker, 1979), and narcissistic issues in particular (Stolorow, 1975). One important departure from the traditional view of libidinized suffering can be found in some of this newer literature; the suffering involved in masochism is viewed as not desired or pursued in itself, but as an unavoidable accompaniment of something else that is desired and sought. For example, there is Benjamin's (1988) intersubjective view that the masochist does not seek suffering, but recognition. However, suffering may result from the pursuit of such recognition.

Masochistic Behavior and Revictimization

Masochism refers to a kind of psychic damage that can be caused by abuse, a certain kind of psychopathology that makes people vulnerable to revictimization, and to the creation of behaviors that seem to indicate a desire for further abuse. A central problem in the motivational construct is that being harmed does not require an unconscious desire for it. One of the fascinating things about masochistic behavior is that it frequently gives the appearance of desired abuse and sought suffering. However, there can be many reasons for behavior that seems to indicate desire for pain and punishment.

Revictimization can have more to do with the immediate situation than with the personality of the survivor. Battered wives have been known to provoke a beating that they know is coming in order to time it most conveniently (for example, so as to cause the least physical damage or not wake the children) or to have some control by simply getting it over with (Miller, 1996). **Another cause of masochistic behavior stems from the biological response to chronic stress.** For instance, are survivors of child sexual abuse or of rape who exhibit danger-courting behavior, pursuing punishment for their libidinal desires? **Van der Kolk** (1987) **has suggested that one motivation of such dangerous activity is that it may stimulate the nervous system to produce calming endogenous opioids which are tranquilizing and can be addictively rewarding.** A similar motivation often underlies much self-cutting and self-mutilating behavior. (Davies & Frawley, 1994). Indeed, many survivors report that they cut themselves because of the physical relief that they experience.

Another biological response is "freezing" behavior, a common response to danger in the animal world. Freezing may provide both camouflage and avoid the predator's strike response, which is triggered by movement. Menaker (1979) has noted the survival value of several types of submissive behavior toward a threatening attacker of the same species. The submissive behavior operates as a biologically inhibiting trigger against the attacker's menacing behavior. Like other animals, humans are also prone to "freeze" when in extreme danger. (Nijenhuis, 1998: Nijenhuis et al., 1998; Terr, 1994). At times, "going limp" and other nonresistance to rape or incest may be the most adaptive response to these dangerous situations. It should be noted that situations of repetitive trauma are likely to produce chronic behaviors that were adaptive to the traumatic situation. Automatic repetition of the submissive or freezing adaptations to originally terrifying situations can be perceived by current observers (or by perpetrators) as inviting abuse.

The tendency towards revictimization is a key aspect of masochism (Shainess, 1970; Prior, 1996) that needs to be understood. For example, Herman (1992) notes that the "risk of rape, sexual harassment or battering . . . is approximately doubled for survivors of childhood sexual abuse." (p.111). With regard to rape, in particular, Diana Russell (1986) found that 65% of the women who had suffered incestuous abuse before age 14 were subsequently raped after age 14. One could say that rather than wishing for victimization, masochists are simply more vulnerable to it. But if this is so, then we need to know why.

Trauma

Since the Vietnam war, the impact of trauma has been increasingly recognized. In the wake of the new understanding of combat fatigue seen in men during and after war, the traumatic stress of some girls and women (Herman, 1992), and boys and men (Gartner, 1999), that results from their daily lives, has come more clearly into focus and is more easily recognizable. In recent years, there has been increasing attention to prevalence figures for child sexual abuse and rape. In the early 1980s, Russell (1986), a sociologist, performed a large epidemiological survey of over 900 women, chosen by random sampling. She found that 38% of them had been sexually abused before the age of 18, 19% had been incestuously abused (p.72), and that excluding incest, 38% were victims of rape or attempted rape (p. 159). According to Koss (1993), "Estimates of rape or sexual assault prevalence among adult women range between 14% and 25% in the majority of sources (p.1,063)." Gartner (1999) estimated that about 17% of boys' experiences of direct inappropriate sexual contact were before the age of 16. Sommers (1994, p, 225) cites the figures of Donaldson, the president of Stop Prison Rape, indicating that there may be as many as 45,000 prison

rapes every day in a prison population of 1.2 million men and calculates that this would make the incidence of male rape as high as that of female rape.

Clearly there is a high rate of trauma inflicted upon girls and women and upon boys and men in our population. **However, masochism is not the only psychological result of trauma. Social and cultural forces tend to exert pressure on males and females in different ways and often create different responses to trauma. Females are more often taught to inhibit aggression, while males are taught to express aggression and to deny dependency.** As a result, more women are pushed in a masochistic direction, while more men are pushed in a aggressive (Gartner, 1999) and/or psychopathic/sadistic direction (Howell, 1996). Of course, this is not to say that there cannot be male masochists.

Masochism is a Response to Trauma:

This new literature on trauma has made it much easier to reconceptualize masochism. A common emphasis of both the older literature on masochism and in the newer material on trauma is on tendencies toward helplessness, revictimization, and self-blame. Indeed, many of the primary "masochistic" traits such as passivity (Horney, 1937), lack of will, (Menaker, 1942) symbiotic enmeshment (Menaker, 1942; Ghent, 1990), self-blame, revictimization, and hypnotic-like helplessness (Shainess, 1970), are also outcomes of traumatic abuse and were described in the psychiatric literature long before the more recent (and considerable) literature on trauma appeared (Howell, 1996; 1997b). **One important aspect of understanding masochism in these terms is moving way from the old focus on the masochist's desire for pain, punishment, and suffering.** This is not to say that masochism does not, or cannot, involve issues of harsh superego; indeed, this can also be reframed as dissociation-based and posttraumatic. (Howell, 1997a).

Masochism is More Than Posttraumatic Stress

There is a difference between posttraumatic stress that does not involve a betrayal of dependent attachment, such as a brush fire—and that which does, such as incest. It is the humanly perpetrated trauma, the betrayal of dependent attachment, that can lead to masochism. Masochism is not merely self-destructive behavior; it occurs in the context of a traumatic interpersonal situation in which the "freezing" or submissive behavior was necessary for survival.

Attachment:

Bowlby (1969, 1984, 1988) has presented evidence that attachment to the caretaker has survival value as protection against predators. But what happens when the caretaker is the predator? What happens to the child's attachment and to the child's aggression? In the masochistic outcome of such a situation, the child preserves attachment at the expense of self-integrity, and may split off the part of the self that experiences aggression. **Thus, the masochistic survival strategy involves attachment-oriented submission and a lack of conscious recognition of the negative feelings toward the caretaker.**

Terrifying and harmful behavior, as well as warm behavior, on the part of abusers, may be intermittent and unpredictable. Abuse can make people feel acutely needy of kindness and warmth. **In traumatic bonding** (Dutton & Painter, 1981) **the battered spouse tunes out the terrifying and abusive aspects of the perpetrator's behavior and bonds with the kinder aspects, which have been idealized.** Freyd (1996) calls this behavior in people who have been traumatically abused, "betrayal blindness." She also proposes that there is a certain kind of cognitive damage involved. She refers to the "cheater detector," a hypothetical mechanism of human endowment proposed by Cosmides and Tooby (Freyd, 1996, p.71). The hypothesis that there is an evolutionary advantage in having the ability to detect cheating is lent support by findings that people are better able to detect rule violation and cheating than they are at simply detecting descriptive rules. Freyd notes that some people who have been traumatically betrayed tend to have damaged cheater detectors. Their damaged cheater detectors have rendered them blind to betrayal.

Freyd also describes what she calls a Consensual Sex Decision Mechanism (CSDM) as a specific version of the cheater detector. People who have been sexually

abused tend to have a damaged CSDM and are thus prone to not attend to the same external cues for danger as do most people: "A damaged CSDM may explain why some people are so vulnerable to subtle external forces (p.173)." She also finds that people who have suffered traumatic betrayal are more likely to not remember trauma involving betrayal than people who have been exposed to other kinds of traumatic situations. Similarly, Richard Kluft (1990) has described the "sitting duck syndrome," which involves an inability to protect the self from violations by others. Like the damaged CSDM, the sitting duck syndrome also develops as a result of child abuse.

In sum, the damage to these mechanisms, which protect the bonding and attachment between the victimized child and the needed caregiver, contributes to the tendency to tune out the dangerous aspects of dangerous people and therefore to be revictimized. Here also, mechanisms of trust and distrust become confused, so that the untrustworthy are too often trusted, while the trustworthy are not recognized.

Dissociation:

Is the wish for attachment sufficient to explain the intensity of masochistic suffering? It seems likely that the intensity of the suffering in masochism is beyond what could be accounted for by attachment need. **An added factor in this complex trauma reaction is dissociation; the severing of experience into segments that are relatively inaccessible to each other.** It is as if these pieces of experience have been placed in different files. Lack of attention to dissociation is another problem with the traditional approach to masochism (according to which the self is conceived of as a unity, which strangely seeks self-harm). Without dissociation, the intensity of the pain and suffering that is often sustained in masochism, simply could not be endured. For instance, extremely painful attachment would not be tolerated; and isolation would be preferable.

One impact of trauma is to render a person utterly helpless. There is an experience of involuntariness (Spiegel, 1990; Ross, 1989; Kluft, 1990, Herman, 1992). Spiegel (1990) says that trauma is "the experience of being made into an object, the victim of someone else's rage, of nature's indifference . . . (along with) . . . the realization that one's own will and wishes become irrelevant to the course of events (p.251)." Dissociation is a frequent consequence of trauma in which segments of experience, memory, and/or identity are disconnected from each other. For instance, a person who is being raped may find that she is not in her body, but is floating above it, observing the situation. Or, a person with a broken leg from a car accident who is lying on a busy highway may find a way to get up and walk to safety without feeling any pain, as a result of dissociation, as well as stress-induced analgesia. The ability to dissociate the physical and emotional pain in these circumstances enhances survival (Freyd, 1996).

Memory and Identity:

Although they are not always distinguished in the literature, it may be useful here to distinguish between dissociation and repression. **Repression usually refers to something that was once known and then banished from consciousness** (Davies and Frawley, 1996), **while dissociation often refers to experience that was never consciously formulated** (Stern, 1998). In addition, repression is thought to be activated by warded-off wishes and by conflict within the personality while dissociation is activated by the utter helplessness experienced during trauma (Spiegel, 1990).

One of the pieces of this masochism puzzle has to do with memory. **Certain memories for factual information may be distorted or lost under the influence of abuse** (Freyd, 1996, Terr, 1994). **What may be left intact are procedural memories** (involving linked behaviors such as skills or memory of how to do things), **and procedural repertoires, such as modes of pleasing, and submissiveness.** Because these types of behavior patterns may be triggered by further abuse, a person who has been sexually abused may falsely appear to be happy about the situation. While the survivor may appear to invite abuse with such behavior, she is more likely to have blocked out informational cues regarding traumatic abuse and to be really at a loss to explain the reason for this state of affairs. Waller, Quinton, and Watson (1995) note that **blocking out of danger cues may occur because the threat schema activates dissociation. People with a history of**

chronic trauma may have learned that certain dangers were inescapable, such that the only relief in the situation was via dissociation. Because it is rewarding, this illusion of escape may perpetuate dissociation and the concomitant perception of helplessness.

As a result of traumatic abuse, a constellation of self-representation, object representation, and associated affect may be split off from an ongoing sense of identity. For instance, often an attachment-oriented, "good" self may remain in consciousness. This "self" may be unaware of having been used exploitatively by a caretaker or attachment figure. This is initially adaptive, for in childhood maintenance of the attachment may be more important for the child than awareness of exploitation. Exploitation and other abuse (physical, sexual, or emotional), are often found to be intertwined with neglect (Kroll, 1993; Zanarini et al., 1997). In a relatively safe environment these types of abuse would be cause for anger and rage. A traumatic circumstance in a dangerous environment, however, may contribute to the dissociation of the experience of rage. A dissociated part of the self may then hold the rage, or of the self as rageful (Howell, 1997b; Blizard, 1997a), **performing a protective function for the person by vigilantly monitoring behavior and affect that would threaten attachment (both of the child to the caretaker and of the caretaker to the child). For instance, a person may vigilantly watch himself or herself so as to not arouse the anger of another person, but be completely unaware of the abusive way he or she is being treated by that same other.** This trauma-based survival strategy produces an attachment to the abuser and a general procedural mode of attachment-oriented submission. In this way, masochism, often an outcome of traumatic abuse, is largely the psychopathology of a self divided against itself (Howell, 1997a).

As a result of dissociating the constellation of the representation of the abused self, the representation of the attachment object as abuser, and all of the rage, pain, and shame that accompanied the abuse, the masochist simply tunes out danger cues. Often the danger cues that are ignored, such as danger of sexual molestation, are the very ones of which the survivor most needs to be aware. For example, one day while Tammy, who was sexually abused as a child, was at work, a strange man walked in and exposed himself to her. She did not consciously notice that anything was wrong at the time and went on with her work. It wasn't until her session that evening that she began to remember with horror what had happened.

A child who has been treated as a possession rather than as an individual with a separate sense of self will have a harder time developing a sense of self as separate from the parents. Furthermore, issues of trust are hard to work out for a survivor who has learned to behave as if she trusts all, yet feels that she can trust no one. (See Brothers' (1995) concept of self-trust.) In either case, the person's internal world, as organized by survival tactics to deal with the outer world, dominates consciousness. As a result of dissociative processes (Bromberg, 1993, 1996), including going into "neutral gear" (Terr, 1994), dissociation in which experience is not formulated (Stern, 1997), and compartmentalization which includes the severing of consciousness, memory, identity, or perception of the environment, a person may be repeatedly subject to abuse, both by others and the self, over and over again.

Hope for Hope

Even though the masochist's world is largely protected by illusion, there is a kind of hope for hope. This is because the masochist has not dissociated attachment need, and this allows for hope and desire for a possible healthy attachment at some point. While masochists may have trouble with whole-hearted trust, they will attach. **The capacity for attachment gives an emotional support for the therapeutic frame, facilitating positive change and healing.** For instance, masochists often have the ability to develop appropriate trust and to take it in when a tender and trusting interpersonal relationship is possible. Westburg (1997) **describes hope as "a significant factor that enhances both mental and physical health and is positively related to successful outcomes in psychotherapy and medical treatments** (p.15-12)."

Case Example:

Jeanne began therapy with me after the recent discontinuation of a previous therapeutic relationship in which she became more and more hopeless and began to contemplate suicide. She had spent the better part of the fifteen years of her adult life in several abusive

relationships, and was still in one. Despite the fact that these men robbed her, assaulted her, or verbally abused her, she had a hard time giving up on these relationships. In fact, even her own descriptions of these relationships made it sound like she was clinging to them. She was very vulnerable to promises of change and to her own fear of being alone. Not surprisingly she had suffered molestation by an uncle and had been severely neglected as a child.

In her previous therapy Jeanne was told that she must have wanted to be abused; otherwise, why would she have permitted it so frequently? Even though she wanted to please her therapist, Jeanne could not find a desire to be abused in herself. In fact, she felt maligned and abused again, but had difficulty expressing feelings about this to her therapist. Jeanne experienced the therapist's approach as rejecting rather than accepting of her angry feelings.

As the author understood it, Jeanne's unrecognized angry feelings had triggered dissociation and the original traumatic situation was reenacted in the treatment setting. In the new treatment we have been able to examine her longing for attachment throughout her life in general, and, more particularly, her feelings of wounded attachment in the previous therapy. Her tendency to tune out angry feelings so as to stay attached has been highlighted. Importantly, the negative transference involving these angry feelings toward the therapist has been dealt with in the current treatment. The author has also focused on the positive aspects of the hope for hope in attachment. The patient has been able to leave her abusive relationship. She has become less depressed, less anxious, more truly hopeful, and more successful in her life.

Guidelines for Effective Treatment

1 ***When appropriate, make clarifying and interpretative statements as to the genesis of the attachment-serving function of masochistic behavior, in particular, the tendency to dissociate and tune out danger cues.*** This mitigates self-blame and the patient can begin to consider the clear effect of an abusive environment on her or his own personality organization.

2 ***Address awareness of affect.*** A person may be alternately flooded by affect or appear to have flattened affect. But a focus on changes of affect may help to make a bridge between affective states, or, alternatively, may flesh out the areas that are being kept out of awareness. It is particularly important to give attention to anger. When this emotion can be communicated to someone who is listening it can usually be felt and owned. This reduces dissociation, self-persecution, and self-blame.

3 ***Give attention to agency.*** This strengthens self–other boundaries. While masochists need empathy, both for rage and pain, as well as other emotions, they should not be treated as "victims" (Kernberg, 1995). This may sound contradictory because the patient is a victim of abuse and/or neglect. However, therapy is meant to provide the resources for a person who has been a helpless victim to recognize their own abilities and desires. Masochists may have learned methods of survival which are not the best methods for a healthy lifestyle; therapy can help the masochist to learn to be agentic and to recognize the ways they have been agentic in the past. For example, a masochistic person may assume that he or she is helpless in a given situation. This assumption can be challenged, and alternative courses of action can be explored.

4 ***Give attention to dissociation.*** This includes the aspects of self and experience that may be unavailable to consciousness at various times. When appropriate, pointing these areas out helps in the process of integration and the owning of disowned affects and experience. Attending to unformulated experience

(Stern, 1997) which is "the uninterpreted form of those raw materials of conscious, reflective experience that may eventually be assigned to verbal interpretations and thereby brought into articulate form (p. 37)." Formulating uninterpreted experience which has not been consciously pulled together can promote integration and health. Bromberg (1993) calls health the "ability to stand in the spaces between realities without losing any of them (p.166)."

5 ***Help the patient differentiate between past and present.*** While attachment to the abuser was necessary and adaptive in the past, it is no longer. The patient needs to learn other methods for being in relationships. However, the therapist should be aware that assimilating this information can be expected to resurrect separation anxiety and depression.

Summary

This lesson has proposed that we retain the concept of masochism in the mental health literature as a name for an important category of human experience rather than removing it altogether. The removal of the term masochism amounts to throwing out the baby with the bath water. Some of the traditional explanations of masochism (primarily involving the notion of an unconscious wish for suffering) have been examined and a reconceptualization of much masochistic phenomena as a response to trauma has been offered. From the trauma perspective, masochism is viewed as dissociation-based behavior that protects attachment need. Survivors of traumatic betrayal are more likely to put themselves in dangerous positions as dissociation compartmentalizes the self, including the removal from the conscious self of affects such as anger and capacities such as agency. Masochistic tendencies are understood as having been adaptive for the situations from which they emerged; however, more self-enhancing behaviors are more adaptive for the present and can be learned.

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Questions Based On This Lesson

To earn CE credits,answer the following questions on your quiz response form.

33. Freud named three categories of masochism, which include all of the following, *except*:

A. Erotogenic.

B. Feminine.

C. Moral.

D. Masculine.

34. In this lesson, the author has reconceptualized masochism in terms of:

A. The wish to be abused as punishment for forbidden impulses.

B. A surival strategy involving attachment-oriented submission and dissociation of experience.

C. Repression.

D. Depression.

35. Which of the following is *not* true? A battered spouse may have trouble leaving an abusive spouse because:

A. She or he may be frightened that the abuser will become dangerously retaliative to her or himself or to loved ones.

B. She or he has become "traumatically bonded."

C. Her personality is such that she has a need for abuse; thus, this situation meets her or his needs.

D. Although intermittent and unpredicatable, the perpetrator may express caring behaviors as well as terrifying and harmful ones.

36. All of the following treatment approaches would be recommended by the author, *except*:

A. Helping patients to recognize their own abilities and desires—attention to agency.

B. Helping the patient to differentiate between past and present adaptive behaviors.

C. Helping the patient to put together and formulate dissociated experiences.

D. Appreciating the patients ability to become attached and encouraging their hope for hope.

DIRECTIONS
Volume 11 Lesson 10

Counseling Poor, Abused, and Neglected Children in a Fair Society

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Introduction

This lesson provides directions for counseling poor, abused, and neglected children in a fair society. The early intervention and reeducation model proposed here advocates a humanistic revival which demands responsibility, accountability, and prosocial attitudes from all parties concerned with transforming, and being transformed by the youth's ecology in order to improve the welfare and life prospects of the most underprivileged among them.

An increasing number of children are exposed to abuse and neglect whether as victims, witnesses, or perpetrators of violence at home, at school, and in the neighborhood. Violence takes many forms: verbal and physical abuse or neglect from parents, educators, and peers, as well as vandalism, bullying, racial conflict, power struggle, ridicule, and teasing at school and in the neighborhood. The challenge is to provide strategies for change in a fair society (Geiger & Fischer, 1999). To be sure, the guidelines proposed here are not only for counseling professionals, but for all parties concerned with the child's welfare. These include parents, teachers, educators, clergy, and any other responsible adult acting as a parent substitute. The future of our democratic society will be determined by how we treat our most precious assets—our children—and the extent to which we invest resources to improve the life prospects of the most disadvantaged among them.

The Early Intervention Model of Fairness, herein proposed, develops philosophical principles for counseling children and parents in a fair world. It is to be stressed that the ideas these principles are based on can be expressed and applied by individuals from various practices, be they counselors, teachers, parents, or simply people interested in promoting healthy choices for children.

Theoretical Background and Literature Review

A multitude of psychological, social, and cultural factors are linked to abuse, neglect, and violence. The stressful events most often mentioned in the literature on disadvantaged children include poverty, racial discrimination, unemployment, lack of social support, alienation, marital conflict, and poor parenting abilities (Bronfenbrenner et al., 1996; Geiger & Fischer, 1999).

Violence affects children's emotional stability and orientation toward the future, their concentration at school and their world view, and can make them nihilistic, fatalistic, and anomic victims of their own negative attitudes and of the desperate conditions of the urban ghettos (Aluenta, 1982; Donaldson, 1994, 1991; Wallach, 1994). Children who experience violence at home, at school, and in the neighborhood cannot feel secure and trust themselves or their environment (Garbarino & Sherman, 1980; Wallach, 1993). They often exhaust their cognitive energy building defenses against dangers, with little or no energy left for learning (Terr, 1981). Living in emotional chaos, children exposed to abuse and violence often feel helpless, betrayed, and abandoned by adults and the institutions by which they are so unfairly treated (Terr, 1983; Wallach, 1993). The relationship between being a victim/survivor and future offender has long been stressed. **Children exposed to violence and abuse early in life are at risk of modeling violent behavior and perpetuating the cycle of violence as they grow up** (Maxfield & Widom, 1995; Straus, 1991; Wallach, 1993).

Policy planners have requested a crack down-on abuse and violence and have asked law enforcement agents to adopt and implement get-tough policies (Van Den Haag, 1991). Tougher security measures and stricter methods of discipline have also been recommended for the schools (Lab & Whitehead, 1992). However, no amount of policing and formal control could solve these social problems. **In fact, punishment breeds violence. Delinquents and criminals have been found to come from environments in which rules and punishments are harsh, inconsistent, and all too often explosive** (Straus, 1991).

Rather than get-tough policies, the early intervention and reeducation model proposed aims to empower individuals to develop the controls and commitments from within, which, in turn, will prevent them from settling into patterns of violent and aggressive behavior. The uniqueness of these guidelines is that they are not based on educational, psychological, or sociological theories, rather on philosophical principles of 'justice as fairness' (Rawls, 1971).

In *Justice as Fairness* Rawls (1971) devises a decision-making procedure, a hypothetical original position which one can enter into at any time in order to reach fair decisions and principles of justice. The main characteristic of this position is the veil of ignorance. In this position, the parties are to forget their natural assets, talents, and socioeconomic or any other advantage that would lead them to tailor decisions and principles to their own advantage. The procedural constraints of the original position, therefore, forces the decision-makers and concerned parties to be represented only as free and equal moral agents and guarantee that the institutions and their two principles chosen to regulate them will be fair. Under this procedure two principles of justice are formulated.

The first principle posits the priority of liberty that cannot be traded for additional socioeconomic advantages. This principle is of fundamental importance for practitioners who constantly face the issue of deprivation of liberty in considering patients' or clients' commitment to institutions. Based on this principle, institutionalization has to be the last resort.

The second principle, the difference principle, regulates the distribution of moderately scarce socioeconomic goods, wealth, power, prestige—and most importantly, the social basis of self-respect. It provides a criterion for judging the fairness of the inequalities allowed by socioeconomic institutions by taking the standpoint of the least-advantaged representatives of a practice. Inequalities are fair only if they improve the condition and prospects of the least-advantaged members of a practice. The difference principle reads as follows, "Socioeconomic inequalities are to be arranged so that they are both (a) to the greatest benefit of the least advantaged, and (b) attached to offices and positions open to all under conditions of fair equality of opportunity" (Rawls, 1971: p. 83).

The device of the original position with its veil of ignorance allows rational self-interested individuals to reach the same decisions as individuals who are capable

of ideal role taking and empathy because they have reached Kohlberg's (1971) highest stage of moral development. In both cases, individuals commit themselves to universal principles of justice, such as the difference principle, and are ready to live by these principles no matter what their natural assets, talents, and socioeconomic status, or no matter what those of their children turn out to be.

In a fair society, individuals realize that the development of their talents and capabilities depends upon the social institutions that have promoted them (Rawls, 1971), and that no one deserves greater natural capacities any more than he or she deserves a better socioeconomic position. These are both arbitrary from the moral point of view. The members of a fair society also realize that self and common interests are not antithetical and may be harmoniously espoused when developing a sense of community and fraternity. **When members of a community become integrated into overlapping groups and involved in community enterprises, they realize that their destiny and that of other members of society are intertwined. Only in a social union could individuals self-actualize—not by each becoming complete in her or his self—but by meaningful work within a just social union.** Rawls (1971) explains that an individual's potential far exceeds what he or she could hope to realize in a lifetime. **By participating in many social unions, individuals with similar or complementary talents could cooperate to overcome partiality and finitude, and realize their common nature. In such a society people would grasp the value of community; individual and common good would no longer be antithetical, but complement one other. Therefore, when citizens come into contact with fair institutions they will, in due time, drop the I-Win-You-Lose Zero-Sum Game and live by the oftentimes forgotten values underlying a democratic society—dignity, mutual respect, and fraternity.**

It is to be specified that several basic concepts adopted in psychology and educational theories go beyond these theories into the realm of philosophy. Core beliefs about human nature, its needs and wants, the issues of free will versus determinism, nature versus nurture, and freedom and responsibility are philosophical matters that will not be solved empirically. The degree of responsibility and accountability expected will vary as a function of these beliefs.

For instance, to view mental illness, crime, drug addiction, poverty, vandalism, violence, abuse and neglect as related to genetic causes is to espouse a deterministic model, often known as the medical model. Within this model people are no longer considered to be free agents, but the helpless victims of biology with little or no control over their behavior. Their degree of responsibility for their fate is minimal. The issue of consent does not arise. Helping professionals may intrude upon a patient's life with impunity.

The more the nature side of the nature-nurture controversy is stressed, and the more our culture puts its faith in biological determinism, the more politicians will be able to maintain a clear conscience while eliminating social and welfare reforms from their agenda. Their basic line of justification could always be that, in the last analysis, it may be unfortunate, but it is beyond their power to change the genetic programming of the underprivileged, which would make them better suited to climb the ladder of opportunity.

A few scientists have begun to realize that the nature-nurture controversy is futile and of little importance. Just as an impoverished environment can harm genes, rich and challenging experiences may, at the genetic level, produce proteins that would act as neurotransmitters to stimulate better thinking and behavior (Bronfenbrenner et al., 1996; Herbert, 1997). Therefore, within such a perspective, a necessary condition for actualizing the optimal genetic potential of underprivileged children is to create for them a stimulating and enriching environment.

> *It is to be specified that the assumption of whether people are free or determined is a philosophical and not a psychological question. However, to become more than a logical possibility, that is socially and psychologically feasible, a philosophical model must be consistent with social sciences findings. Simultaneously, the advantage of a philosophical model, such as the one proposed here, is to cast light upon and provide justification for psychological and educational theories and findings (Kohlberg, 1971; Rawls, 1971).*

Assumptions of the Early Reeducation Model of Fairness:

The philosophical model of justice as fairness casts light upon and provides justification for psychological and educational theories and findings. Its assumptions are the basis of the counseling principles presented in this report, and represent a system of beliefs which are diametrically opposed to those underlying the biological or medical model.

People are assumed to be rational, free, and capable of autonomously deciding among various conceptions of the good life. Simultaneously, the notion of accountability is emphasized in the relationship between freedom and responsibility. Individuals are free to the extent that they are responsible and accountable for the consequences of their actions. People are assumed to have potential moral capabilities and a sense of justice which they may not have actualized as yet. However, it is because of this potential that claims of justice come into play and allow for the application of the two principles of justice.

An Early Intervention Model of Fairness

Applying Principles of Justice to Children:

The application of just principles to institutions affecting children allows us to draw important directions for counseling. **Children are neither as free, nor as responsible as adults; their immaturity reduces their decision-making capacity and, therefore, makes them less accountable for their actions.** Rather than liberty, children are entitled to welfare, protection, love, intellectual, and emotional stimulation, and any other psychological and social ingredients needed for the future exercise of liberty. However, based on the priority of liberty, institutionalization of children must be a last resort. Children may not be deprived of their liberty for the sake of improving their living conditions.

Equality of Opportunity, Difference Principle and Least Advantaged Children:

When considering social change and reforms, clinicians and counselors must apply the difference principle and therefore look at the system from the perspective of the least advantaged. From among various arrangements or practices they must choose the alternative that will improve, if not maximize, the long-term prospects of the least advantaged under conditions of equality of opportunity.

Parents' wealth, the quality of education they can afford, as well as the support and encouragement that, teachers, and other agents of socialization provide influence the child's development and prospects. Since no child deserves more wealth, better education, or better day-care centers and schools, improving the prospects of least advantaged children cannot be done in the abstract without effectuating global changes in their ecology. To do so, short of creating state nurseries, one has to maximize the socioeconomic, psychological, and intellectual resources available to all children including the quality and intensity of the interpersonal relationships that encircle them.

Given that children's destiny is closely tied to that of their parents, one must first improve the prospects of their family. Survey statistics point to the feminization of poverty and to the fact that most disadvantaged families are fatherless and composed of single teenage mothers and their children. These mothers live in slums, suffer from drug addiction, inadequate health care, and alcoholism. Oftentimes they have been the victims of employment discrimination, physical and verbal abuse, and sexual exploitation (Banyard & Olson, 1991; Boals et al., 1990; Geiger & Fischer, 1999).

As Rawls (1971) *justly points out, severe socioeconomic deprivation undermines self-respect and the value individuals have in liberty.* Research findings have also indicated that mothers in poverty have a negative self-image and low self-respect. They often feel betrayed and powerless because of the abuse they have experienced. Yet, they are marginalized as being poor, promiscuous, and immoral, and as being responsible for their own misery. These women usually endorse a fatalistic attitude toward life and espouse gender stereotypes that oppress and constrain their choices and opportunities (Banyard & Olson, 1991). They often have no option left but to fulfill the prophecy of being losers while repeating the cycle of violence and poverty.

Directions to Improve Mothers' Life Prospects:

- Help disadvantaged mothers build confidence in their ability to do something worthwhile. Implement various self-awareness and assertiveness training techniques to help women gain confidence in themselves and become autonomous (Kestenbaum, 1977).

- Teach mothers that they have the power to influence their own destiny and that they are responsible and accountable for their behavior. These goals cannot be achieved in a social vacuum. Opportunities for self-empowerment requires the acquisition of marketable skills that will enable underprivileged women to become productive and involved members of society.

- Encourage mothers to leave unemployment and welfare as a way of life through the development of vocational and technical skills needed in the job market. The counselor's task, in this context, is to obtain the cooperation of businesses to sponsor vocational training and apprenticeship programs that would train and place women on the job. Incentives such as tax breaks or matching funds may be provided for hiring women or teenagers. Women will obtain a salary, health insurance, and day care while learning a trade.

- Initiate daily group support and discussions for mothers facing similar challenges. Counselors will use the principles of Guided Group Interaction to empower women to become their own center of decision making (Empey & Erickson, 1972; Fischer & Geiger, 1994). In these daily group meetings women will exchange information, raise questions, and create their own resolutions for problems they have to confront concerning educational and job training, work, or parenting skills. The counselor will remain at the periphery of the group process and act as facilitator.

Day Care and Multiple Emotional Centers:

Early childhood psychologists have warned us about the irreversible damage of late intervention due to the government's unwillingness to regulate and subsidize quality day care, and the inability of the poor to afford such care. Head Start beginning at four or five years old may already be too late to induce lasting change (Galinsky, 1990; Olds, 1988; Thompson, 1988; Zigler & Trickett, 1978). Therefore, Head-Start programs starting at childbirth made available to all children are necessary.

Since children's life prospects are undermined by incompetent, dysfunctional, and abusive parents, it is important to counterbalance the negative impact of such parents and dilute the potential conflict stemming from them by multiplying the child's emotional bonds. Additional emotional centers and anchors of support besides those provided by the parents can be found in day care, at church, or in the neighborhood. These will prevent traumatic bonding, isolation, and entrapment of the child in the explosive hot-house of emotions that constitutes the nuclear family (Gelles & Strauss, 1979; Inglis, 1978).

Margaret Mead (1954) was one of the first researchers to realize the beneficial importance of creating additional bonds to avoid explosion and relieve tension: ". . . cross-cultural studies suggest that adjustment is most facilitated if the child is cared for by many warm, friendly people (p. 477)."

- Day-care workers and home-visiting adults can provide children from abusive and violent families with a corrective emotional experience. The bond with others who have become significant in their lives helps children from violent homes break the cycle of violence and find alternative ways of relating to others.

- **Students, dedicated community members, ministers, scouts, older youths, or classmates function as models while they assist the child with homework and peer relations, and initiate more positive mother-child relationships.**

- **After-school programs stimulate the intellectual and emotional development of underprivileged preschoolers and kindergartners and allow them to acquire the skills needed for schools success and social competence.**

- **Day-care centers and schools can become the heart of the community. Activities such as parties, picnics, and shows performed by children with the parents' cooperation strengthen children's and parents' bonds to the community and gradually reduce feelings of estrangement and alienation.**

Guidelines for Improving Parenting Skills

Oftentimes parents do not know how to treat or deal effectively with their children. Since parenting requires more responsibility than driving a car (which requires one to obtain a license), for instance, parents need to acquire appropriate skills to take care of their children's needs. Lessons in parenting can be given to fathers and mothers from the first days of the infant's life, at the same time as they are instructed on how to feed, burp, and diaper the infant. Parents will learn about the proper style of parenting, discipline, and the importance of the fathers' involvement in infant and child development (Geiger, 1996).

Authoritative Style of Parenting:

An authoritative style of parenting that stresses the proper balance of limit setting, love and support is recommended (Baumrind, 1971). Love and support may be expressed verbally and non-verbally to the child. A parent's hug or kiss or an educator's tap on the shoulder, smile, eye contact, and physical proximity are non-verbal indicators of fondness. Furthermore, it is not enough for parents to assume that their children must know how much they love and care for them. Parents must explicitly show their love and tell their children how much they love and care for them. Expressions such as "I care for you," "I love you," and "I am there if you need me," must be communicated by parents.

Parents and educators must also be instructed that discipline fails when it is too lenient or too authoritarian. Children must feel that they are loved, trusted, and respected. Educators must show children that they recognize their presence. A simple "Hello! How are you today!" may suffice to achieve this. Counselors have to teach parents and educators to respond to children enthusiastically and with empathy. Applying clear and consistent rules, using reason and logic in one's explanations, placing high expectations on children, while showing love and respect, helps children develop self-control, independence, and a sense of responsibility (Galinsky, 1990). Children raised in this mode reach optimum development and are able to express positive feelings about themselves and have greater confidence in themselves and others.

Punishment:

Physical punishment may temporarily relieve adults' frustration and anger, but it degrades and demoralizes children, making them lose the most important primary goods: dignity and self-respect (Straus, 1991). As a result, children's respect for adults' authority weakens as their faith in justice disappears. Violence, anger, and hostility follow. Piaget, in this context, comments, "It is not the obligatory character of the rule laid down by an individual that makes us respect this individual, it is the respect we feel for the individual that makes us regard as obligatory the rule he lays down" (Piaget, cited in Hirschi, 1969: pp. 29–30).

Positive and negative reinforcemen[illegible]re much more powerful ways to change or strengthen a behavior than after-the-fact punishment. A reinforcement is positive when the desired behavior is followed by a stimulus that the child wants. In this context, counselors and clinicians cannot merely assume that they know what children or teenagers like. The use of the Premack (1965) principle, which has been successfully applied with out-of-control children,

will assist them in selecting reinforcers (Geiger, 1996; Homme, 1966). This principle states that a highly preferred behavior, that is, a behavior that has a high probability of occurring, may be used as an effective reinforcer of less preferred activities that have low frequency occurrence. For this purpose, they must observe what children like to do in their free time.

Negative reinforcers are also very effective in changing behavior since they give children the opportunity to gain control and the responsibility to change their behavior. Negative reinforcers strengthen a behavior by allowing the aversive consequence(s) to disappear. A classic example is that of buckling our car seatbelt in order to escape the aversive buzzing sound. It is up to us to stop the buzzing sound, which stops once we buckle. Therefore, rather than telling a child "You will not go out because you have not studied for your test!", which is to punish, counselors will use negative reinforcement in their statement, "As soon as you study for your test, you no longer have to stay at home and may go out!" This message conveys that it is under the child's control and choice to perform the behavior—studying—required to terminate the unpleasant, aversive situation—staying at home.

Reactive Versus Proactive Mediation of Peer Relationships:

On the basis of the study they conducted in a day care, Howes et al. (1994) concluded that the type of mediation of peer relationships most often used by caregivers in the United States was reactive. Parents, day-care workers, and other educators intervened only when children had gone too far, to break up a fight, scold, or reprimand, or to put the child in time out. These punitive measures may prevent children from acting in a certain way, but do not guide them toward the appropriate behavior. The result is often social maladjustment and problem behavior.

All those acting in loco parenti cannot be content with reactive measures. They must be encouraged to model and facilitate prosocial behavior while using proactive mediation of peer relationships. Within the proactive model of mediation, educators do not stand by as passive bystanders. By their words and behaviors they enact prosocial values and guide peer interaction toward more cooperation, mutual help, and solidarity. They actively model and teach self-respect, respect for others, and accountability. The institution of these practices may be hard to comprehend in a society which has, for so long, professed individualism and cutthroat competition (Bronfenbrenner, 1970). Nevertheless, educators can no longer remain indifferent. Violence and anomie will be reduced only in a milieu that stimulates concern for others, the ability to put oneself in anothers' place, and empathy (Gilligan, 1980).

Paternalistic Principles

In order to protect the child's emerging autonomy and decision making ability, all the decisions of those acting for the best interest of the child will be constrained by paternalistic principles.

The first paternalistic principle states that decisions must be guided by the child's own wishes and preferences as long as they are not irrational. When these wishes are not known, decision making must aim at maximizing all-purpose goods such as wealth, and most importantly, self-respect (Rawls, 1971).

Developing Decision-Making Ability:

- **View children as gradually developing their decision-making ability and as needing less and less interference as they reach maturity. When these capacities are fully mature, children will be allowed to make autonomous decisions concerning their options and goals in life (Gewirth, 1978; Locke, 1960; Rawls, 1971).**
- **Emphasize that children's autonomous decision-making ability is not an all-or-nothing capacity that suddenly pops up at the age of maturity, but rather a gradual process that requires a stimulating environment to unfold.**

The second paternalistic principle states that all those acting in loco parenti should guide rather than substitute their opinions for those of their children. Children's consent is, therefore, required. Indoctrination is never justified since it would permanently destroy the child's decision-making ability.

Respecting the Youth's Wishes and Preferences:

- **Respect the youth's wishes, needs, and preferences. Counselors must clarify and relate to the problem the youth addresses to them, even when they have identified more complex or pressing ones. They must adopt the youth's perspective and guard against invading her or his privacy.**
- **Be aware that the term irrational may be misused by anyone, especially when children's wishes do not correspond with those of adults. Even Gewirth's (1978) interpretation of irrationality, which is anything that could harm the child, has to be considered with caution when it comes to psychological rather than eminent physical harm since it remains within the loophole of who is to decide what is damaging to the child!**
- **Use methods which will eventually make indoctrination ineffective by leading children to become their own center of decision making. If children are given the opportunity to make decisions while exposed to information from all perspectives of an argument they will learn to respect their own as well as others' decisions.**

America's Educational Abyss: Alternative Routes to Self-Worth

Apathy, anomie, aggression, drugs, and delinquency are some of the problems educators face in our educational abyss. Frustration and negative attitudes toward school may start early and for many reasons: school failure, racial discrimination, or the irrelevance of the curricula.

Oftentimes, youths at risk have lost all hope to achieve, succeed, and gain acceptance through normative means. At this dead end, educators must realize that formal and academic studies may not be for everyone and that alternative routes to formal education should be available to all youth needing it. Vocational skills are as valuable as academic ones, therefore, a culture that provides only one avenue for self-respect—academic success—is not balanced because it deprives many individuals from feeling capable of doing something worthwhile (Kornhauser, 1978). On-the-job training in prominent community businesses, night and vocational schools, and adult education courses are legitimate alternatives to gaining status from antisocial behaviors, gangs, or hate subcultures (Arthur & Erickson, 1992).

Meaningful Work and Experience:

According to Redl (1965), all youth are, in fact, disadvantaged, because they do not have opportunities for meaningful work and experience. They are growing up alienated from the world of adults, and deprived of adequate role models and authentic responsibility. Redl (1965) also described adolescence as a moratorium without oxygen, in which there is nothing worth doing:

> *"What is the good of a leeway to experiment, when there is nothing for them to experiment with? The urban youngster of my country finds himself in a vehemently infantilized and highly pauperized life-space. His chances for a meaningful work experience, for the opportunity to make a meaningful contribution to society at his own level are quite poor and no amount of 'recreational facilities' can make up for that fact!" (1965: 277).*

For the same reasons, Goodman (1960) adds that growing up in our industrial society is growing up absurd. Isolation of youth from work creates angry and cynical youngsters with no specific satisfaction except, maybe, drugs and "conspicuous consumption."

- **Give youth opportunities to become responsible as they engage in various community enterprises. As part of the curriculum, and for credits, students can volunteer in depressed areas in order to develop role-taking ability and assume the perspective of the more indigent. They can be encouraged to visit various com-**

munity organizations such as Alcoholics Anonymous, prisons, and churches, and perform community services such as providing food to the needy, implementing a neighborhood renewal program, or being a mother's helper and a needy child's big brother.

Using the Group as a Vehicle for Change:

Implementing Guided Group Interaction and autonomous decision making among peer group members or classmates will decrease the pressure to compete and foster a cooperative atmosphere (Murphy, 1988; Wasserman, 1976). Capitalizing on the physical, emotional, and cognitive resources of the group, classmates or peer group members would formulate creative solutions to the challenges and problems posed in the community, such as delinquency, drug abuse, and violence. Youth gain confidence and a sense of competence as they implement innovative ideas (Empey & Erickson, 1972; Fischer & Geiger, 1991, 1994).

Sharing Power and Authority:

In the world of adults, youth are often viewed as threatening troublemakers. When confronting youths, adults fear losing control. Adults are often convinced that they must present a strong united front to prevent youths from walking all over them. They must retain control even at the cost of using threats, coercion, power play, and authoritarian tactics such as, "You do this, or else!" These techniques may produce short-lived obedience and ritual compliance, yet most of the time they are accompanied by long-term disasters. This is especially the case for at-risk youth who have grown immune to all techniques of coercion, making them unwilling to cooperate and commit themselves to more appropriate ways of behaving.

- **Remind all those acting in loco parenti that they are mature and should act responsibly. For that matter, they must avoid entering into power games and de-escalate power struggles when they occur (Gordon, 1989).**

Power struggles produce rage, hostility, and rebellion, rather than responsibility, self-reliance and self-discipline (Burke, 1992; Glasser, 1990; Gordon, 1989; Kohn, 1993). Taking responsibility is far more important than obeying authority (Curwin & Mendler, 1992) Responsibility develops gradually when youth become emotionally involved with people who act responsibly (Glasser, 1990) and are given the opportunity to sort out facts and make decisions. Relating freedom to responsibility, Gordon (1989) requests alternatives to power and authority "that will produce human beings with sufficient courage, autonomy, and self-discipline to resist being controlled by authority when obedience to that authority would contradict their own sense of what is right and what is wrong" (Gordon, 1989; 98).

- **Power and authority shared between adults and youth will empower youth to change their behavior. Teachers, educators, and especially youth workers who have successfully survived abuse and violence, provide youth with positive role models. They may be firm about the rules and put high expectations on youth, but always with regard for the youth's dignity.**

Preventing Verbal Abuse:

Any form of verbal abuse or aggression is to be prevented since it hurts young persons self-concept and dignity when their character, competence, background, and/or physical appearance, rather than the issue at hand, is being attacked (Sabourin et al. 1993). Verbal abuse is dangerous because it often escalates and degenerates into physical violence (Gage, 1988; Sabourin et al. 1993; Strauss, 1974).

Verbal abuse has been found related to a deficiency in argumentative and problems-solving skills. When people do not have the ability to argue constructively and defend their position, they will attack. (Infante et al., 1996; Sabourin et al., 1993). Verbal abuse was also found to occur when one person attempts to gain power and control over the other (Gottman, 1982; Millar & Rogers, 1987), as well as

when the people involved are incapable of expressing negative emotions in constructive ways. (Yelsma, 1995).

- **Guide adults and youth to develop better interpersonal communication and problem-solving skills. Clarify the difference between being assertive, argumentative, and verbally aggressive, that is, the difference between focusing on the issue at hand rather on than on the other person's deficiencies. Counselors will also train the parties to become aware of and express negative emotions in acceptable ways (Mack, 1989; Yelsma, 1995).**
- **Teach adults and youth to express disapproval by using I-messages, such as "I am mad" or "I am very upset", rather than you-messages such as " You cannot do anything right!" I-messages allow thoughts and feelings to be expressed about the situation and other's behavior without attacking their dignity, ridiculing them, or putting them down (Ginott, 1972; Gordon, 1989).**

When Verbal Abuse Degenerates Into Physical Aggression:

Aggressors must realize that the use of force and violence is under their control and a matter of personal choice, just as is the use of normative means when the immediate cost-benefit ratio of their actions is considered. The variability in the use of violence often lies in the calculation of long-term, as opposed to short-term, goals. The planning of long-term goals is rare for at-risk youth (Gottfredson & Hirschi, 1995). Violence will be reduced once the youths are empowered to develop consequential thinking and change their violent scripts and thinking patterns by adding long-term goals to life plans.

Conflict Resolution and Mediation:

- **Enlist mediators and neighborhood referees of the same ethnic and socioeconomic background.**

Neighborhood mediators are better able to put themselves in the place of at-risk youth who live in an at-risk neighborhood, with at-risk parents. They are better at understanding and making others understand that the negative behaviors of at-risk youth are often modes of adaptation to the adverse conditions these youth face (Curwin & Mendler, 1992). Neighborhood mediators will be trained in a short training course in conflict resolution given by volunteer law school students or lawyers. Thus, they will be able to help the parties work out a peaceful resolution of their conflict before it escalates into more violence and retaliation. To work out their conflicts, parents and their children may have the choice to go to neighborhood mediators, the priest or rabbi, rather than to counselors in the helping professions. This choice will often be determined by the influence, significance, and degree of credibility these change agents have in the eyes of both parents and children. Victim/Survivor awareness programs and sensitivity training will focus on the harm done. Survivor-aggressor confrontation sessions will enable survivors to explain to their aggressor how the violent incident has disturbed their lives and the pain he or she had to endure. Such sessions are expected to make the aggressors aware of the survivors' suffering, develop empathy, and subsequently accept responsibility for their actions (Dittenhoffer & Ericson, 1983).

Meaningful Communication:

Alienation and isolation of youth will persist as long as there is no authentic communication between adults and youth. Youth desperately need to communicate with adults who are ready and have time to listen to them, not in depersonalized chat rooms or cyberspaces, but in real life. This type of communication requires that the content of the verbal message and the style of the communicator protect and affirm the youth's self-concept and dignity regardless of the position defended. This occurs when communicators are warm, friendly, relaxed, and attentive rather than sarcastic, belittling, cold, and cynical. Other important ingredients of authentic communication are active listening and understanding the message behind the utterance (Wolfgang, 1995). For instance, a youth who utters curse words and constantly uses the words "bitch!" or " what the fuck!" is expressing distress behind his or her utterance. Such utterances may also be the red light for

emotional or sexual abuse and helplessness. Counselors must be aware of these messages of distress and frustration. Genuine communication guides youth and challenges them to face reality. Active and careful listening gives youth recognition. This allows them to define and identify their problems individually or in a group in order to brainstorm resolutions, evaluate, plan, and implement solutions.

Conclusion

The assumptions of freedom and responsibility at the basis of the early intervention reeducation model presently proposed have far-reaching implications for counseling. While rectifying social and moral deprivations, this model neither has a color nor aims at "fixing" the poor, neglected, and abused children without their consent. To be sure, just a philosophical model to become more than a logical possibility has to be supported by social sciences findings; this reeducation program to become more than utopian directions, must be supported by substantial funding invested in socioeconomic and welfare reforms. Guided Group Interaction, problem-solving skills, conflict resolution, negotiation, assertiveness training, authentic communication, on-the-job training and placement, and other components of the proposed project, when funded, would pull the underprivileged above the line of desperation and help them appreciate the value of liberty. Empowered to make autonomous decisions and to be responsible for their destinies, the poor and abused would develop a sense of dignity and a desire to struggle for a better life, to which they are entitled.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

37. According to the author, get-tough control policies and stricter methods of punishment will:

A. Allow authorities to crack down on violence.

B. Solve the problem of violence.

C. Breed more violence, abuse and delinquency.

D. Exhaust the cognitive energies of the student dealing with violence.

38. The reeducation model proposed in this lesson aims at increasing all of the following, *except*:

A. Early intervention.

B. Student's responsibility and accountability.

C. Sharing power between adults and youth.

D. Formal controls.

39. To overcome partiality and finitude and realize our common nature as human beings, Rawls would recommend to develop all of the following, *except*:

A. A sense of community.

B. Competition.

C. Social union.

D. Cooperation.

40. What form of parenting emphasizes a balance between limit setting, love and support?

A. Authoritarian parenting

B. Noninvolved parenting

C. Authoritative parenting

D. Permissive parenting

DIRECTIONS
Volume II Lesson II

Chronic Fatigue Syndrome: Assessing Symptoms and Activity Levels for Treatment Planning

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Introduction

Recent community-based studies involving representative samples of ethnically and socioeconomically diverse populations indicate that chronic fatigue syndrome (CFS) is one of the most prevalent and debilitating of all chronic health conditions (Jason, Richman, et al., 1999). Despite increased research efforts in the past 15 years, CFS remains a controversial disease with unknown cause. CFS has no definitive diagnostic markers, no cure, and no uniformly reliable treatments (Jason, Wagner, et al., 1995; Jason & Taylor, in press). **Contributing to the slow progress in CFS research is a lack of consensus among health care professionals regarding diagnostic criteria, etiology, and diagnostic label** (Jason, King, et al, 2000). **At the community and personal level, afflicted individuals encounter disbelieving attitudes from their doctors, family, and/or friends which is indicative of the controversy surrounding CFS.** As a result, effective and timely intervention on behalf of the Person With CFS (PWC) is frequently delayed or never obtained.

This lesson focuses on methodological concerns relevant to improved accuracy of differential diagnosis, assessment, and treatment planning for the person with CFS. Current approaches to diagnosis and assessment typically rely on measures that record only the occurrence of various symptoms related to CFS at one point in time. Such approaches do not provide information on either the severity of symptoms or fluctuations in symptom severity and

activity level that occur over time. Consequently, these measures do not reveal complexities and interrelations among symptoms; an awareness of these complexities is very important to understanding the patient's situation.

In this lesson, a survey of empirical research and case studies identifies the special challenges to diagnosis and assessment of CFS, and research is reviewed that demonstrates the diagnostic value of combining actigraphs and selected self-report scales of symptoms and functioning. Self-report measures that have been developed to assess physical, psychological, and social functioning of the individual with CFS are described and application of this more sensitive system of assessment is discussed in the context of treatment planning and management of activity levels and symptoms.

After completing this lesson, the clinician will be able to (1) recognize the symptoms of CFS, (2) assess patients for symptoms and the interrelationship of symptoms with activity levels, and (3) identify therapeutic interventions aimed at managing, or even reducing, CFS-related symptoms.

Clinicians who are able to identify and assess individuals with either diagnosed or unrecognized CFS will increase the likelihood that CFS patients receive appropriate treatment. Moreover, the earlier patients receive constructive intervention, the less likely the patient is to suffer trauma arising from the serious symptoms of CFS.

Prevalence of CFS:

CFS occurs in approximately .42% of the population, or approximately 800,000 U.S. citizens, and affects all aspects of life and functioning, including employment and activities of daily living (Jason, Richman, et al., 1999). Random, representative, community-based **research indicates that this syndrome is particularly common among women and afflicts people from different ethnic backgrounds and socioeconomic groups.** As shown in Table 1, **prevalence of CFS is higher for Latinos and African Americans than for Caucasians, and higher for individuals of lower socioeconomic status** (SES) than for those of higher socioeconomic status (Jason, Richman, et al., 1999). Further, **Latinos who are female, older, and of higher SES report the highest relative severity of fatigue** (Song, Jason, & Taylor, 1999). Factors contributing to higher rates of CFS among low-income groups and ethnic minorities may include psychosocial stress, behavioral risk factors, poor nutrition, inadequate health care, more hazardous occupations, or environmental exposures (Jason, Richman, et al., 1999).

Diagnosis of Chronic Fatigue

Diagnostic Criteria:

Friedberg & Jason (1998) note that several definitions of CFS have been proposed, but not empirically derived (Jason, Wagner, et al., 1995). Considerable research and clinical effort is underway to improve the accuracy and applicability of diagnostic criteria for CFS (Jason, King, et al., 2000). Currently, a majority of

Table 1

MEAN PREVALENCE RATES OF CHRONIC FATIGUE SYNDROME (CFS) IN U.S.A. (PER 100,000 PERSONS)

	CFS Prevalence Rate
Total	422
Gender	
Female	522
Male	291
All	422
Ethnic Identity	
White	318
Latino	726
African-American	337
Other	491
Age	
18 – 29 years old	315
30 – 19 years old	412
40 – 49 years old	805
50 – 59 years old	413
60 + years old	354
Occupation	
Unskilled/semi-Skilled worker	436
Skilled worker	701
Professional	325

Adapted from Jason and colleagues (1999) with the permission of the author.

researchers and clinicians use the diagnostic criteria established by Fukuda and colleagues (1994):

A thorough medical history, physical and mental status examinations, and laboratory tests must be conducted to identify underlying or contributing conditions that require treatment. Diagnosis should not be made without such an evaluation. Clinically evaluated, unexplained cases of chronic fatigue can be classified as CFS if the patient meets both the following criteria:

(a) **Clinically evaluated, unexplained persistent or relapsing chronic fatigue that is of new or definite onset (i.e., not lifelong), is not the result of ongoing exertion, is not substantially alleviated by rest, and results in substantial reduction in previous levels of occupational, educational, social, or personal activities**

(b) **The concurrent occurrence of four or more of the following symptoms: substantial impairment in short-term memory or concentration; sore throat; tender lymph nodes; muscle pain; multi-joint pain without swelling or redness; headaches of a new type, pattern, or severity; unrefreshing sleep; and post-exertional malaise lasting more than 24 hours. These symptoms must have persisted or recurred during six or more consecutive months of illness and must not have predated the fatigue.**

Challenges to Accurate Diagnosis:

In practice, diagnosis of CFS is missed in about 90% of the existing cases (Jason, Richman, et al, 1999). **Sometimes inadequacies in medical awareness of diagnostic criteria and/or biases in medical perceptions of fatigue-related illness prevent individuals from receiving correct diagnosis and treatment** (Jason, Richman, Friedberg, et al., 1997). **Lack of precise, operationalized guidelines to assess Fukuda et al.** (1994) **criteria leads to variability in interpretation** (Jason, King, et al., 2000). For example, how should the practitioner reliably "score" concepts such as persisting or relapsing fatigue, new or definite onset, ongoing exertion, or substantially alleviated by rest to achieve accurate assessment? As for the eight minor symptom criteria, empirical literature demonstrates that it is possible for a person without CFS to fulfill Fukuda criteria if only broad measures, limited to occurrence or nonoccurrence of specific symptoms, are used (Friedberg & Jason, 1998). This binary method provides little information about the patient's symptom severity and about fluctuations in symptom severity and activity level that occur over time (Jason, King, et al., 1999).

Another difficulty is that CFS shares a number of symptoms besides fatigue with many other organic and psychiatric disorders. Measures must be carefully chosen to identify organic causes of fatigue and other symptoms and to distinguish CFS from psychiatric disorders that are often mistaken for CFS (Friedberg & Jason, 1998; Taylor, Friedberg, & Jason, 2001).

Clinicians should also be aware that patients progress through different phases of adjustment to the CFS experience. Fennell (1995a, 1995b) suggests that people pass through **four different stages of adjustment to their symptomatology: crisis, stabilization, resolution, and integration. A patient's responses during assessment will likely vary according to phase and, thereby, present a varying clinical picture with associated treatment needs.**

Assessing Symptoms

Clearly, accurate assessment of CFS is fraught with pragmatic and theoretical difficulties. Mental health practitioners may refer to the works of Friedberg and Jason (1998), Jason and Taylor (in press), and Taylor, Friedberg, and Jason (2001) for comprehensive overviews of empirical literature about these issues. Drawing from these works, this lesson will focus on clinical use of measures that have been empirically validated with CFS populations.

Assessment Perspective and Initial Interview:

CFS is not a "mind" or "body" phenomenon, but rather a transactional one. CFS affects virtually every aspect of a person's functioning and interaction with

the environment. The illness results in severe, prolonged fatigue as well as neuropsychiatric, rheumatological, and infectious symptoms (Friedberg & Jason, 1998). The physical and psychological shock of CFS onset combines with the experience of social stigmatization to create an enormous burden for the patient (Fennell, 1995a). **Many people with CFS** (PWCs) **experience profound losses in their support systems** (Jason, Richman, et al, 1997).

Although other explanatory models of CFS have been proposed, accumulating empirical literature lends support to the psychoneuroimmunological perspective (Taylor, Friedberg, & Jason, 2001). **This model suggests that complex interactions of neurologic, immune, and endocrine systems work in conjunction with environmental and psychological factors to influence the onset and clinical course of CFS.** The fluctuating nature of an individual's CFS illness is related to his or her ongoing biopsychosocial experience, operating from the individual's genetic substrate. **In the assessment process, the clinician should consider the whole person and their constructed identity in relation to CFS symptoms, impairments, and activity levels; and to immediate and extended environments and life activity.**

The assessment process should begin with a semi-structured clinical interview that meets the client at whatever level of disclosure in which he or she is willing to engage. Some clients may focus on neurocognitive and physical symptoms; others may describe the emotional, interpersonal, and/or life functioning concerns. As the interview progresses, the clinician may ask specific questions about illness-related changes or losses, as well as issues involving self-concept and adaptation to CFS. Relevant questions may include: What symptoms are troubling you now, and when did you first notice them? Is the pattern or severity of your illness substantially different today than earlier in its course? Do any symptoms get worse with stress or overexertion; do any improve with rest? How has your illness affected work, family, social and recreational activities? Have you discussed your health with family, friends, or coworkers; if so, did they respond as you expected? What strategies have you used to cope with this illness and with what results? The goal of this first interview is to obtain an empathic understanding of the presenting problems from the client's perspective. **The clinician should carefully pace the interview, checking the client's reactions and energy levels periodically to protect the client from becoming so physically and emotionally overwhelmed that they would be reluctant to return for further treatment.** For example, the clinician should watch the client for signs of increasing fatigue or physical discomfort; increasing emotional distress; and increasing "brain fog" as suggested by difficulty in formulating responses or a loss of train of though. **The client should also be alerted to the possibility that more difficult topics may elicit emotional reactions which could lead to increased fatigue and exacerbation of symptoms.** Throughout the assessment and treatment process the client should be reminded and encouraged to inform the clinician about his or her physical state.

After the initial interview, a variety of assessment tools are available to evaluate psychological, physical, and social functioning; cognitive coping style; health care practices; and access to resources. This lesson describes some of the measures that are particularly useful in assessing symptoms and activity levels of clients with CFS. **Measures that offer open-ended or dimensional rather than yes/no responses increase the scope of information and, therefore, accuracy of diagnosis. Repeated measurement of symptoms over time is essential to capture fluctuations in severity and occurrence of symptoms. Charting by both practitioner and client:**

1. **Aids identification of symptom patterns**
2. **Allows for the prioritizing of symptoms to be addressed over the course of treatment**
3. **Provides feedback regarding the impact of the patient's coping strategies on health status**
4. **Confirms presence of ongoing illness despite seemingly significant improvements in symptom severity and/or number. Activity levels should be quantified and studied in relation to perceived energy, fatigue, and other symptoms, and to qualitative aspects of energy expenditure.**

Psychological Functioning: CFS Screening and Differential Diagnosis

When CFS is being considered as a diagnosis, the CFS Screening Questionnaire is a valid and reliable screening device developed to detect cases of fatigue within the general population and to serve as a preliminary screening measure of self-reported CFS symptoms (Jason, Ropacki, et al., 1997). The questionnaire consists of two parts: Part 1 assesses sociodemographic characteristics, fatigue severity (Chalder et al., 1993), and interference of fatigue with usual daily activities. Part 2 is administered to individuals who report six or more months of chronic fatigue in Part 1. Part 2 assesses for the presence of the eight minor symptoms of CFS (Fukuda et al., 1994) and also measures characteristics associated with fatigue such as fatigue duration, frequency of fatigue, attributions regarding the cause of fatigue, and fatigue-related functional impairment. Part 2 also contains a series of questions assessing previous diagnosis of any other medical or psychiatric conditions associated with chronic fatigue (Taylor, Friedberg, & Jason, 2001).

The physician may refer the CFS patient to a psychotherapist for treatment of depression or anxiety, or to learn coping skills for the illness. Friedberg and Jason (1998) review empirical literature that distinguishes CFS from other medical and psychiatric disorders that involve non-CFS chronic fatigue. **One key feature that distinguishes CFS from depressive psychiatric disorders is exercise intolerance. Attempts to increase endurance and reduce symptoms via high levels of physical exercise often result in symptom flare-ups rather than improvements.**

Salient differences between CFS and the psychiatric disorders, often mistaken for CFS, are summarized below.

1. **Generalized loss of interest or of enjoyment is unusual in CFS.**
2. **In CFS, mood and energy tend to be higher in late morning, not worse, as in depression.**
3. **Severe, persistent fatigue is the central feature of CFS, but is seldom so prominent a complaint among depressed patients.**
4. **Onset of CFS can be quite sudden, whereas symptoms of melancholic depression develop over weeks or even months.**
5. **Sleep disturbances in CFS tend to involve delayed sleep onset rather than early morning waking common in depression.**
6. **Problems of poor concentration are much more profound in CFS than in depression and mental efforts to improve concentration may generate more fatigue and cannot be sustained by the person with CFS.**
7. **Prolonged, severe fatigue after exercise is very common in CFS, whereas exercise is often beneficial in relieving depression.**
8. **Self-reproach symptoms, such as guilt or feelings of failure, are more common in depression than in CFS.**

Somatization disorder shows considerable overlap of symptoms with CFS. However, fatigue is the primary symptom of CFS, and not a listed criterion of somatization disorder. Also, pattern of onset is different: CFS patients usually report a sudden onset of the symptoms in their late 20s to late 30s; initial symptoms of somatization disorder begin in adolescence and escalate over several years to a fully developed state by age 25.

Generalized Anxiety Disorder and CFS both present with fatigue, difficulty concentrating, sleep disturbance, and other minor symptoms, but clinical presentation is quite different. **Severe debilitating fatigue is the primary feature in CFS, whereas excessive persistent worry is most prominent in generalized anxiety disorder.**

If a structured form of psychiatric interview is preferred, ***the Structured Clinical Interview for the DSM-IV*** (SCID; Spitzer et al., 1995) **assesses comorbid psychiatric disorders**. Unlike other measures of psychiatric disorders, such as the Diagnostic Interview

Schedule (DIS) and Beck Depression Inventory (BDI), which tend to overdiagnose psychiatric illness in CFS patients (Taylor & Jason, 1998), the SCID allows open-ended questions and incorporation of context-specific information essential to distinguish medical from psychiatric symptoms. Since the SCID incorporates information about the complexities of a patient's CFS experience, it offers a more detailed diagnostic picture.

Physical Functioning: Tools for Assessing CFS Symptoms and Fatigue:

Two objective measures have been developed for clinical use to distinguish individuals with CFS from those with other illnesses. ***The CFS Symptom Report Form*** (see Appendix C of Friedberg & Jason, 1998, for this measure) **obtains self-rating of levels of fatigue, CFS definitional symptoms,** and other somatic and cognitive symptoms frequently experienced by people with CFS. Questions about onset and longevity of symptoms, and the impact of CFS on social/recreational and work activities are included. A recent refinement of the CFS Symptom Report Form is the ***Chronic Fatigue Syndrome Self-Report Questionnaire*** (see Taylor, Friedberg & Jason, 2001, Chapter 3, Table 1). **This measure is modeled after the Fukuda** (1994) **case definition and enhanced by the inclusion of questions that assess the presence of symptom patterns identified empirically in people with CFS.** It, too, offers a broad objective picture of a patient's CFS symptoms, fatigue levels, and CFS-induced alterations of life activities.

To assess functional status, the ***Medical Outcomes Study Short form-36 Health Survey*** (MOS SF-36; Ware & Sherbourne, 1992) **evaluates several dimensions of functioning: physical activities, mental health, social functioning, bodily pain, energy, and fatigue.** Validated with CFS samples, it distinguishes gradations of functional impairment.

The Fatigue Severity Scale (FSS), **developed by Krupp et al.** (1989), **provides a rapid assessment of fatigue-related impairments.** Comparisons of this test with the Fatigue Scale by Chalder and colleagues (1993) suggests that the FSS represents a more accurate and comprehensive measure of fatigue-related severity, symptomatology, and functional disability for individuals with CFS-like symptomatology (Taylor, Jason, & Torres, 1999).

Assessing Coping, Social Support, and Phases of CFS Illness

The ongoing stress of CFS triggers coping responses that may profoundly affect adaptation to diminished abilities and intrusive symptoms. The client's style of coping, perspective of illness symptoms, and personal priorities and values should be taken into account when devising a treatment plan. Longevity of CFS illness experience bears on these variables as well. Past and current health care behaviors, and access to and utilization of resources for practical and other forms of social support should be assessed to identify variables that may help or hinder the client's efforts to cope with CFS.

Tools for Assessment:

The Fatigue-Related Cognitions Scale (Friedberg & Jason, 1998, Appendix D; Friedberg & Krupp, 1994) **may be used to obtain a working map of symptom attribution and underlying beliefs that impact adaptive health care behaviors and emotional response to CFS;** maladaptive beliefs that perpetuate overexertion are of special interest.

The Illness Management Questionnaire (IMQ), **developed for CFS assessment, identifies four dimensions of coping strategies: maintaining activity, accommodating the illness, focusing on symptoms, and information seeking** (Ray et al., 1993). The IMQ scales capture the dynamic qualities of the problem-focused coping characteristics needed for a chronic, fluctuating illness such as CFS. The IMQ does not assess emotion-focused coping.

Quality of Life Index (QLI), **developed by Ferrans and Powers** (1992) **and found to be effective with CFS samples populations** (Anderson & Ferrans, 1997), **measures four major facets of quality of life: health and functioning, social and economic, psychological/spiritual, and family.** This index takes into account the fact that each individual may prioritize aspects of life quality differently; this measure aids identification of issues relevant to individualized treatment planning.

The Fennell Phases Inventory (Jason, Fennell, et al, 2000) **accurately differentiates four psychosocial phases of CFS illness experience: crisis, stabilization, resolution, and integration.** As an educational

tool for the patient, the Fennell model and inventory results confirm and clarify the physical and psychosocial consequences of CFS and may lead the way toward improved ability to cope with illness burdens.

Assessing Physical Functioning and Activity Levels

When assessing CFS, current activity level and lifestyle must be contrasted with premorbid activity level and lifestyle. Some people with CFS appear to be functioning well. However, when their premorbid activity levels are contrasted with current levels, their degree of impairment and disability becomes apparent. Some people with CFS may sacrifice their social activities to conserve enough energy to continue their occupational and family activities.

Because fatigue levels are such a prominent and defining symptom of CFS, a behavioral approach using methods which assess activity levels over time provide an advantage in describing activity levels and symptoms of CFS. **Levels of physical activity may be assessed directly by having individuals with CFS: (a) wear a mechanical or electrical activity-monitoring device; (b) recall and report their physical activity; or (c) maintain activity logs or diaries.** Tennen and colleagues (2000) report that handheld computers, which record symptoms and activities as they occur, are effective in studying the temporal relationship of stress, coping, and emotions as factors in other clinical problems. Application of this technique to measurement of activity levels and symptoms in CFS may have clinical value for CFS populations.

Actigraphs are electrical monitoring devices that can be worn on the waist 24 hours per day for a specified number of days and can be programmed to record at 1-minute intervals. Actigraphs quantify movement intensity and store data for up to 22 days. A recent study demonstrated the value of using actigraph data to assess activity levels in patients with CFS (Jason, King, et al., 1999). A healthy control subject had regular spiking of activity units, with high variability in activity during the day and low variability at night. In contrast, the subject with CFS did not exhibit the high spiking of activity units and produced less clearly defined patterns of high daytime variability and low nighttime variability.

The actigraph should be used to measure objective changes in daily activity levels and to compare physical functioning at the beginning, middle, and end of treatment. To accompany actigraph output, the client should complete an "Energy and Fatigue Record" (Jason, Tryon et al., 1997). This record allows the client to document daily self-ratings of perceived energy (how much energy she or he thought was available that day) and expended energy (how much energy was used during the day). The client rates these energy levels on a scale of 0 (extremely low) to 100 (extremely high).

In addition, the client should be asked to maintain a daily record of sleep–wake activity and total hours of sleep per 24-hour period. CFS is very stress sensitive. Fatigue and other symptoms generally wax and wane in relation to level of activity, whether intellectual, emotional, or physical. **Notations about diet, as well as emotional and cognitive forms of exertion or stress may be valuable additions to the daily record. Information generated may provide insight into behavioral or emotional patterns that lead to the worsening of fatigue and CFS-related symptoms. Also, self-monitoring facilitates active engagement by the client in the treatment process.**

Treatment Planning

The approach to treatment must be comprehensive, addressing a variety of needs. **Preliminary findings support the efficacy of cognitive behavioral interventions in improving functional impairments in people with CFS. However, controversy exists over the use of graded levels of exercise, the value of rest versus activity, and appropriateness of the client's attributions of CFS illness to biomedical or psychosocial factors** (Jason & Taylor, 2000).

Two complementary forms of cognitive behavioral therapy that have been found to be beneficial to many people with CFS are **cognitive coping skills therapy** (Friedberg and Krupp, 1994) **and cognitive behavioral treatment incorporating principles of envelope theory** (Jason, Melrose, et al., 1999). **Neither model questions the client's belief in a medical cause for CFS.** Both take an individualized approach to treatment planning.

Cognitive coping skills therapy focuses on the identification of symptom relapse triggers and

encourages activity moderation to minimize setbacks. This therapy also emphasizes cognitive and behavioral coping skills, stress reduction techniques, and use of social supports in an effort to promote self-regulation and management of CFS symptoms.

Using principles of psychoneuroimmunology, *envelope* theory provides a transactional model that supports complex interactions between multiple biological and psychological factors that influence the onset of CFS and its course. Envelope theory recommends that people with CFS pace their activity according to their available energy resources ("energy envelope"). By avoiding both overexertion and underexertion, the client maintains an optimal level of activity over time. Findings of CFS studies reported by King, Jason, and colleagues (1997) and Pesek, Jason, and Taylor (2000) **indicate that when participants monitored their levels of perceived** (available) **energy and adjusted expenditure so as to approximate perceived energy levels** (staying within the envelope), **participants experienced decreases in fatigue and improvements in CFS-related symptoms over time.** These subjective ratings of energy have been found to correlate positively with actigraph ratings which measure the intensity and frequency of movement (Jason, Tyron, et al., 1997)

Monitoring and regulating activity levels in the interest of managing fatigue and other symptoms is a primary therapy goal. Therapy based on envelope theory can be combined with cognitive coping skills therapy (Friedberg, 1995) to treat a wide range of functionality. **First, the client should be carefully socialized into essential elements of cognitive behavioral therapy and patient–therapist collaboration.** To obtain baseline data, the client wears an actigraph for 2 to 3 weeks to record movement intensity. During that time period, the client also completes an Energy and Fatigue Record to track variations in energy resources. Each evening before going to bed, the client rates the amount of energy that seemed to be available for the day (perceived energy) and how much energy was used during the day (expended energy) as well as the severity of fatigue experienced. Ratings are completed on 100-point rating scales. A rating of 0 indicates extremely low levels of perceived energy and no energy expenditure, respectively. Ratings of 100 indicate extremely high perceived and expended energy levels. Fatigue severity is rated from 0 (no fatigue) to 100 (extreme fatigue). Ideally, the client also keeps a daily diary to record the nature of each day's events: physical activity; social, cognitive, and emotional effort; and general observations of symptoms. This data collection process may be repeated at middle and conclusion of treatment for comparative purposes.

Using the above information, the client is encouraged to observe the relationship between perceived versus expended energy levels and fatigue intensity. With practice, the client becomes more adept at recognizing perceived energy level at any particular moment and may moderate activity to remain close to the perceived level. Some clients may find that they need to curtail excessive activities to avoid a "crash" (symptom exacerbation and especially severe fatigue); others who are not active enough may be able to increase activity cautiously without triggering a "crash." **Comparison of actigraph output and the Energy & Fatigue record data in relation to the descriptive information contained in the diary allows identification of patterns and triggers to overexertion across a spectrum of functioning. Maladaptive behaviors and beliefs are uncovered and analyzed by client and clinician with an eye toward generating short-term, flexible, and attainable goals designed to maintain energy and reduce frequency of setbacks. When the patient's energy levels become more consistent and symptoms more manageable, the client is encouraged to make a list of desired activities, prioritized and rated for predicted energy requirement. As the client feels stronger, activities from the list may be added to daily life.** Envelope theory encourages people with CFS to organize and plan to avoid overexertion, but, at the same time, to stay as active as possible within the range of available energy.

Marked reductions in fatigue symptomatology and increases in energy may occur over time with some CFS patients, although ongoing symptoms and functional limitations still meet criteria for the diagnosis of CFS. Health care providers should not assume that these improvements indicate recovery. It is expected that positive changes in outlook and decreased feeling of isolation will accompany the changes in beliefs and activity patterns introduced by this form of cognitive

behavioral therapy. Given the many symptoms of this complex illness and its highly variable symptomatology, comprehensive assessment with appropriate self-report measures combined with objective activity measurements offer an effective foundation for cognitive behavioral interventions for people with CFS.

Summary

Random, representative community-based research indicates that CFS is one of the most prevalent and disabling of all chronic health conditions in the United States. Despite recent research efforts, CFS is a disease with unknown cause, no definitive diagnostic markers, no uniformly reliable treatments, and no cure. Diagnosis of CFS is missed in about 90% of existing cases. Factors contributing to this problem include inadequacies in awareness of diagnostic criteria, biases in perceptions of fatigue-related illness, lack of precise guidelines to assess diagnostic criteria, overlap of CFS-related symptoms with those of other organic and psychiatric disorders, high variability of symptoms and impairments within and between patients, lack of public information about CFS, and poor access to medical resources.

CFS is a highly individualized illness and affects virtually every aspect of a person's functioning and interactions with his or her environment. Current approaches to diagnosis and assessment of CFS rely primarily on scales that measure only the presence or absence of various symptoms and, thus, do not reflect the high variability and interrelations among symptoms over time. Consequently, health care professionals may be prevented from understanding the complexities of this disease. A psychoneuroimmunological perspective offers a framework to (a) elucidate the fluctuating nature of a person's CFS illness in relation to ongoing biopsychosocial experience and personal physiology, and (b) guide the assessment and treatment process.

Assessment should include a semi-structured interview, multidimensional self-report measures, and actigraph measurement of activity intensity over a period of time sufficient to account for variations in the client's health and life activities, at least one week, but preferably 2–3 weeks. The lesson describes a variety of measures found useful to evaluate the impact of CFS and to identify behaviors and beliefs that may influence treatment planning and outcomes. Particularly useful are: measures of fatigue and other CFS-related symptoms; records of perceived versus expended energy levels; objective measurements of activity intensity; and self-report records or diaries of emotional, cognitive, and physical exertion. These measures should be employed over a period of weeks to reveal individual patterning of symptoms and activity levels as well as triggers to exacerbation of symptoms. Repetition of these measures at mid-point and end of treatment may be compared with baseline data. Self-monitoring facilitates active engagement by the client in the treatment process.

A combination of cognitive coping skills therapy and cognitive behavioral treatment incorporating principles of envelope theory has been found effective in helping individuals with CFS to manage symptoms and increase energy and activity levels. Cognitive coping skills therapy focuses on identification of symptom relapse triggers and encourages activity moderation to minimize setbacks. Envelope theory recommends that people with CFS pace their activity according to their available energy resources ("energy envelope"). By combining actigraph output with daily records of fatigue and energy levels and other information obtained over several weeks, the patient observes the relationship between perceived versus expended energy levels and fatigue intensity. Identification of maladaptive beliefs and behaviors that contribute to overexertion paves the way for cognitive behavioral interventions tailored to the needs of the individual. Over time, cognitive behavioral treatment using envelope theory and cognitive coping skills therapy enables the patient with CFS to experience improvements in overall functional status.

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

41. Diagnosis of chronic fatigue syndrome (CFS) is difficult due to which of the following variables?

A. Variability among clinicians and researchers as to interpretation of diagnostic criteria.

B. CFS shares a number of symptoms besides fatigue with many other organic and psychiatric disorders.

C. CFS symptoms are remarkably varied and, along with activity level, fluctuate in severity over time.

D. All the above

42. Which of the following statements is *not* correct?

A. Past and current healthcare behaviors should be among the areas assessed.

B. In generalized anxiety disorder, excessive persistent worry is most prominent. While a person with CFS may worry, severe debilitating fatigue is the primary feature.

C. Progressive, graded exercise is an important component of treatment for individuals with CFS.

D. The patient's coping style and beliefs about illness should be taken into account when developing treatment plans.

43. In assessment of individuals with CFS:

A. Due to problems of memory and concentration, current activity level is best measured with an actigraph worn for 2–3 days.

B. The Beck Depression Inventory and the Diagnostic Interview Schedule are comparable to the Structured Clinical Interview for the DSM-IV for assessment of comorbid psychiatric disorders.

C. Questions about impact of CFS on social/recreational and work activities are of marginal value.

D. None of the above

44. According to the authors, which of the following statements is *not* correct?

A. The primary goal of treatment is the monitoring and regulating of activity levels in the interest of managing fatigue and other symptoms.

B. The patient should be advised that their illness does not have a medical cause.

C. As the patient experiences improvement in energy levels, new activities of the patient's choice are added on a prescribed schedule.

D. Comparison of actigraph output and Energy & Fatigue record data with information in daily diaries allows identification of patterns and triggers to overexertion across a spectrum of functioning.

DIRECTIONS
Volume 11 Lesson 12

The Limitations of the DSM-IV as a Diagnostic Tool

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Introduction

The *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a reliable source for psychiatrists and members of other disciplines who need to make accurate diagnoses and communicate about them. Psychiatry has begun to hold its diagnostic system comparable to those used by other practitioners of medicine; this implies that psychiatric disorders have consistent etiologies, treatments, and treatment outcomes. However, such claims tend to diminish the fact that psychiatry is substantially different from the other disciplines of medicine. Many psychiatric disorders remain unexplained in terms of causative agents or physiology. In contrast, most medical diagnoses are based on objective findings, even though diagnostic certainty varies for each condition. The diagnosis of cancer, for example, is based on observed structural pathology; pneumonia, on the presence of a bacterial or viral agent; hypertension, on deviation from a statistical norm. Only for a few conditions commonly seen in general medicine is a given diagnosis (such as headache) based purely on the patient's recital of symptoms. **In psychiatry, no matter how scientifically and rigidly the clinician uses scales to estimate the patient's pathologic symptoms, the diagnostic process is still one of empirical pattern recognition.**

The enormous task of organizing the diagnostic process for each mental disorder was accomplished most successfully in the third, third-revised and fourth editions of the DSM (DSM-III, DSM-III-R, and DSM-IV, respectively). But the DSM remains an arbitrary system of diagnosis. **Each diagnosis in DSM-IV is based on expert opinion and not etiology.**

DSM-IV has been accepted worldwide by psychiatric organizations. It has been used to increase communication about psychopathologic entities, it has provided a strong basis and stimulus for research, it has served as a guide for treatment and teaching. But its very success and utility has desensitized practitioners to its problems and short-comings. This lesson will consider various strengths and limitations of DSM-IV, with special attention to its use in everyday practice.

In reading this lesson clinicians will: (1) become familiar with how the steps in the construction of DSM-IV differed from those for early DSMs; (2) note some of the strengths of this diagnostic scheme; (3) be alerted to the risks and dangers that reside in depending too much on diagnosis alone as a way to comprehend the complex nature of mental illness; (4) recognize the importance of focusing on the understanding of patients, and (5) plan appropriate and effective treatment regimens.

Historical Overview of the DSM Process

Only during the past two decades have American psychiatrists paid much attention to nosology and diagnosis. In the past, diagnosis often seemed like an exercise in "Yankee Individualism." The first *Diagnostic and Statistical Manual of the American Psychiatric Association* (DSM-I) was published in 1952 (American Psychiatric Association [APA], 1952). Prior to that, there was a *Statistical Manual for the Use of Hospitals.*

It was not until World War II that problems due to the lack of a diagnostic system became apparent. The Armed Forces, confronted by an increasing psychiatric caseload, found that the *Statistical Manual for the Use of Hospitals* was of little help; it could only be used to classify about 10% of the cases they saw (APA, 1952). Consequently, the Armed Forces created its own nomenclature; after the war, the Veterans Administration also designed a diagnostic nomenclature. By the late 1940s, American psychiatrists were faced with at least four diagnostic nomenclatures. In addition, none of these diagnostic schemes bore any resemblance to the International Statistical Classification of Diseases (ICD; Cooper, 1994). Because of this diagnostic chaos, the APA formed a task force in 1948 to create a diagnostic system that was uniform and consistent. In 1952, the DSM-I was born (APA,1952) It was revised in 1968 to update the nomenclature and to make it more consistent with the ICD-8 (APA, 1968). Interestingly, many members of the committee that created the DSM-I were also on the DSM-II committee.

During the 1960s and early 1970s, the DSM-I and DSM-II were not used in a large part of American psychiatric practice. However, by the late 1970s, American psychiatry became far more interested in diagnosis and nosology. Thus, the DSM-III signaled a great change in our field. Many factors brought about this increased interest in nosology. **Perhaps the most exciting stimulus for more interest in nosology was the advent of effective psychopharmacological agents. Suddenly, instead of the universal treatment—psychotherapy—the clinician had access to specific treatments for depression, anxiety, schizophrenia, and manic depressive illness. It became important for the clinician to discover the "right" diagnosis so the "right" medication could be prescribed.** It also became apparent that **research had to expand from individual patients to groups of patients** to answer some of the questions about the effectiveness of treatment. **To develop better diagnostic criteria, homogeneous groups of patients had to be studied (Astrachan, et al., 1972; Feighner et al., 1972).**

In addition to the advent of psychopharmacology, inpatient psychiatric units were developed in general hospitals during the early 1960s. Prior to World War II American psychiatry was mostly an outpatient specialty. The seriously mentally ill were taken care of in large public and private institutions, usually in a rural setting far from the referring psychiatrist. Consequently, the majority of psychiatrists in private practice seldom treated patients with serious or chronic illnesses. Hospital psychiatrists had the most experience with patients who had chronic illnesses or acute psychoses. Not surprisingly, most of the psychiatric community had little interest in the DSM-I and -II, which were used mostly by a small group of hospital psychiatrists. **As more psychiatrists became active members of general hospital medical staffs, they became exposed to a broad range of acute psychiatric problems—psychosis, depressions, delirium, and dementia—as well as medical illnesses that looked just like schizophrenia or depression but were caused by seizure disorders, strokes, head trauma, and other disturbances of central nervous system function.** In the hospital setting, American psychiatrists rediscovered the brain. It soon became apparent that our nomenclature was inadequate and that we needed better ways to classify patient disorders. These and other factors led to the development of the DSM-III. Consequently, the DSM-III task force was organized very differently from previous DSM committees.

The DSM-I and -II were created mainly by a "committee of the whole," i.e., a single committee provided the criteria for every diagnostic category. **DSM-III was created by small work groups, each composed of experts for each diagnostic category.** For example, the organic disorders work group for DSM-III (APA, 1980) and DSM-IIIR (APA, 1987) was made up mostly of consultation liaison psychiatrists. The radical change this work group brought about in the classification of the organic disorders reflected their experience in general hospitals.

Clinical practice clearly delineated the need for such categories as delirium, dementia, and amnestic disorders. As Lipowski has pointedly stated, "...delirium has become established as the designation for the most common and most important acute organic brain syndrome. This development became finally enshrined in DSM-III" (Lipowski, 1990). **In addition, DSM-III recognized four organic syndromes that did not display the traditional cognitive symptoms of brain damage but whose major manifestations were behavioral.** These disorders, which were due to nonpsychiatric medical and surgical disorders, were organic delusional syndrome, organic hallucinosis, organic affective syndrome, and organic personality syndrome. In 1987, DSM-IIIR added organic disorder. DSM-III was a radical change from DSMs I and II; like its predecessors, however, it was still based primarily on expert opinion and case reports.

Two main reasons were cited for the timing of the DSM-IV. One was to make the DSM nomenclature compatible with that of ICD-10. The other was **to take advantage of all the research produced for DSM-III and DSM-III-R regarding specific diagnostic criteria; thus, the diagnostic criteria became more "data based" than before** (Frances et al., 1989; Frances et al., 1990; Widiger, 1991). **The DSM-IV organic disorders work group provides a good example of how expert opinion was used.** By the time the DSM-IV task forces were set up in 1988, considerable psychiatric expertise had evolved regarding the behavioral aspects of brain disease. Specialized research and clinical centers for Alzheimer's disease and epilepsy had been established in most major academic centers; almost all of them included psychiatrists in key positions (Fillenbaum, et al., 1997). Several major textbooks and journals devoted exclusively to neuropsychiatry and behavioral neurology were newly available, and a renewed interest in geriatrics brought with it studies of the aging brain. Many of the breakthroughs in imaging techniques, molecular genetics, and molecular biology made the study of the central nervous system and its relationship to behavior one of the most exciting areas of medical investigation. The interests of the DSM-IV work group on organic disorders mirrored that relationship. The members of this work group were not primarily consultation liaison psychiatrists; most of them were neuropsychiatrists, and all had done research on delirium, dementia, movement disorders, seizures, or neuropsychology (APA, 1994).

The DSM-IV Process

The first task each DSM-IV work group (13 in all) undertook was to solicit comments from the field—mainly from psychiatrists and mental health professionals as well as other appropriate healthcare providers, depending on the needs of the diagnostic category. For example, the organic work group drew heavily from neurologists and neuropsychologists. **The opinions of both national and international experts were solicited for each DSM-IIIR category.** The next step was to do **a comprehensive literature review for each diagnostic category to determine the *utility* of specific diagnostic criteria.** Once this process of review and commentary was accomplished, the next step was to formulate preliminary ideas and **examine them in light of existing research, clinical patient data, and, in some cases, field trials** (Frances, et al., 1989, 1990).

Proposed changes in DSM-IV were submitted to the entire DSM-IV task force for discussion. **Any proposed changes had to have compelling support based on research data;** changes were not to be made solely on the basis of expert opinion. **The results of these deliberations were then resubmitted to consultants and professionals in the field**—first in draft form, then in the form of an options book—well before the final draft of DSM-IV was to be made. The entire process was very open; opinions were sought from all disciplines that are affected by the DSM-IV (e.g., social workers and psychologists).

Strengths and Limitations of DSM-IV

Strengths:

DSM-IV introduced a nomenclature based on explicit diagnostic criteria. It also provided a multiaxial format that helped to identify clearly all components needed for clinical care (e.g. medical illnesses, social factors, etc.) **and define the complexity of psychiatric diagnosis. The multiaxial format required the clinician to note not only the diagnosis, but also the patient's personality, pertinent medical illnesses, psychosocial and environmental problems, and global functions.** DSM-III and its successors have **increased communication between psychiatrists, psychologists, and other mental health professionals. The explicit criteria have spurred research into the epidemiology of mental disorders, specific diagnostic categories** (particularly affective and anxiety disorders) **and treatment outcomes. It has allowed the teaching of medical students, graduate students, and practitioners of other disciplines to become more focused and structured. The DSM-IV multiaxial format also has also been very useful for patient education.** *Many distressed patients and their families, particularly those with mood or anxiety disorders, are often reassured after seeing their symptoms listed almost verbatim in DSM-IV that they actually have an illness.* For both patient and practitioner, the DSM-IV has gone a long way to demystify mental illness.

Limitations:

DSM-IV is limited more by the way it is used than by the structure of its nomenclature. People have begun to think of the DSM-IV as a textbook of mental illness. Some faculty believe their main task is to teach the corpus of the DSM-IV to their students. **Clinicians also have a tendency to believe that once they make a diagnosis they actually know something about the patient, when all it really means is that a particular label fits—or, as is most often the case in clinical practice, *almost* fits—a particular patient. For some clinicians, the DSM-IV diagnosis has become too much of a concrete entity which sets in motion a subsequent chain of events,** ie, the diagnosis dictates the treatment, the length of treatment, and the outcome. It is this type of thinking that delights most litigators' malpractice cases and the authorizers of managed care.

The misuse of the DSM-IV can cause subtle problems. *I first became truly aware of the potential problems associated with the misuse of the DSM while at a teaching conference.* A resident presented the case of an 18-year-old woman with an eating disorder who was being treated with behavioral techniques. The presentation began as follows: "This 18-year-old girl became preoccupied with her figure and lost 25 pounds in the 3 weeks preceding admission." *At this point, I stopped him and said that it was rare, in my experience, for a patient with an eating disorder to experience such an acute weight loss and asked him if anything else was going on in the patient's life?* Finally, a nurse noted that about a month before the patient's admission, her father left his wife and family and ran off with his secretary. Immediately following this trauma, the patient stopped eating and became preoccupied with her weight. *Somewhere, the patient's story had become lost.* **What was being treated was a diagnosis and not the patient.** For me, this was an illuminating event. What happened here? These were not incompetent clinicians. It became increasingly clear that **in current mental health treatment, patients' stories, information, and the ways in which patients relate their experience of an illness to other aspects of their lives are not necessarily considered integral to the diagnostic process.** In this case, the symptoms were sought but not the antecedents or consequences of these symptoms.

Recent data indicate that the search for symptoms colors the clinician's perception of the patient's ability to function. Roy-Byrne and colleagues (1996) compared psychiatrists' diagnoses (obtained by using the Psychiatric Symptom Assessment Scale and the Global Assessment of Functioning [GAF]) with those of nurses who rated the same patients for functional level using Lehman's Quality of Life Scale. Roy-Byrne and colleagues showed that **the psychiatrists' ratings were based more closely on the patients' symptoms than on the patients' ability to function.** Halleck (1988) pointed out further that DSM-III seemed to focus the trainee on the diagnostic process and not the patient. It is clear that **the clinician's view of the patient can become restricted** if only the predeter-

mined symptoms that are needed to make the diagnosis are sought. Not only is clinical attention narrowed, but **important symptomatic and course distinctions among patients can be ignored.** It is important to remember that the clinician is continually evaluating subjective experiences reported by the patient. Can these self-reported symptoms be effectively evaluated without exploring other aspects of these subjective symptoms, such as their antecedents, consequences, and intensity? Jaspers, the great phenomenologist, would say no (Jaspers, 1968).

A brief perusal of any current psychiatric journal seems to demonstrate a loss of interest in observation. There is a strong possibility that relying on the DSM has led to a loss of interest in the study of psychopathology. For example, when examining a patient with schizophrenia, what should impress the student and the practitioner is how this person we call "schizophrenic" takes in the same sensory data that we do yet comes up with a different interpretation of that data. There is something different about the way this person thinks and the way he or she processes information. Currently, most residents will look at you blankly if you mention the phrase *thought disorder.* In 1979, Nancy Andreason did a seminal study of thought disorder, citing 18 different types of speech or thinking disorders that had been described for patients with schizophrenia (Andreason, 1979). At present, our concern about any type of information processing or thinking defect in schizophrenia is expressed by the descriptive term, *disorganization of speech.* **We have lost not only our curiosity about how a psychotic patient thinks but also how to teach our students the variety of possible verbal productions such a patient can make.** We are not looking at the patient's phenomenology anymore, but for the symptoms needed to make the diagnosis. Symptoms that are not necessary for the diagnosis are often ignored, unless the patient has the temerity to continue to complain about them and keeps calling them to the attention of the practitioner.

Many practitioners tend to ask how a patient or group of patients fits into a diagnostic category while ignoring the variety of categories within the patient's psychopathology. Not only has this led to a boring and voluminous new literature, it also tends to lead to trying to ***force-fit*** **all patients into the existing diagnostic categories rather than encourage the development of new ones. We no longer look for variations in psychopathology.** Our current *polythetic* system of diagnosis relies on a variety of symptoms and is called by some the "Chinese menu" approach—one in which **any of the symptoms can be used to make the diagnosis as long as they add up to the required number and no one symptom is key to the diagnosis. This is in opposition to a monothetic system of diagnosis, in which a specific symptom is the *sine qua non* of the diagnosis. As Bleuler postulated, loose associations were for the diagnosis of schizophrenia. This approach, combined with our lack of observational skills, often leads us to compare two quite different groups of patients and place them in the same diagnostic category.**

While standardized diagnostic criteria are necessary for research, **it is not clear that the use of polythetic criteria derived by expert opinion and intended mainly for research is truly appropriate for clinical purposes. The reliance on strict diagnostic categories in the clinical setting, particularly for patients with complex disorders, often makes it difficult to indicate proper treatment.** It has become common to monitor only a few "target" symptoms or patient functions to determine treatment efficacy when the diagnosis is not clear.

Our enthusiasm for this new diagnostic process has also been stimulated by the fact that it makes our clinical practice seem more "medical," (i.e., it allows us to make the "proper" diagnosis and suggests the treatment to follow). However, this medical approach may have unanticipated consequences. **It puts us in the position of being able to "grind out" patients, which has the potential to make psychiatry boring and repetitive and certainly does not serve patients well at all.** Many clinics and university programs have developed productivity standards that are based on a psychiatrist seeing four patients an hour for medication management. This process plays into the hands of those who want to regulate our practice, in that it reduces our practice to the DSM diagnosis and medication management. **The regulators' zeal for this reductionist approach forces us to avoid attending to the complexity of most patient problems.** Central to the care of patients is the fact that *they want to be heard and*

understood; this has a profound influence on treatment outcomes in every medical field. We must be doing something wrong when the pharmacist becomes the most trusted health professional rather than the physician. It is also not inconceivable that students who witness this assembly-line approach to psychiatry believe that they will be treating patients on an assembly line and that if this is what the practice of psychiatry is about, then they might as well "grind out" patients in a more lucrative or more prestigious specialty.

The Concept of Mental Illness

The fascination with and immediate worldwide acceptance of the DSM-III/IV is perhaps a testament to the need to concretize the vagaries of psychiatric and psychological practice, to build a firmer foundation for the disorders we are forced to treat daily. It is important, however, to keep in mind that **these very same entities which we have enshrined in the DSM are not as distinct as we would like to believe.** The question of *whether psychotic disorders are distinct entities or points on a continuum* is discussed in a fascinating monograph edited by Kerr and McClelland entitled *Concepts of Mental Disorder* (Kerr & McClelland, 1991). At first glance, this seems to be a surprising question; certainly schizophrenia is distinctly different from manic depressive illness and a psychotic depression is very different from either illness. But personal clinical experience may suggest that it is more often the exception than the rule that a patient fits the diagnostic criteria precisely; most often it is an *approximate* fit. As one of my major interests is neuropsychiatry—at most case conferences I will be presented with a patient who has some mixture of brain damage and subsequent psychopathology—my most frequent diagnosis (much to the despair of the residents) is, "I don't know what it is, but it's a bad case of it." However, having seen many such cases, several things have become evident to me. **In most cases, we are seeing syndromes rather than clear disease entities.** The same syndrome can have very different etiologies—hallucinations can be due to a seizure disorder, a toxin in the blood, the withdrawal of a toxin in the body, fever, a blow to the head, etc. A patient with a condition like Huntington's disease, which has a clearly defined genetic etiology, can present with symptoms that could indicate a diagnosis of dementia, psychosis, depression or antisocial personality disorder, or a mixture of symptoms indicating several of these disorders. Thus, the genetic simplicity of Huntington's does not assure psychopathologic homogeneity. **The similarity of syndromes and symptoms tells us little about whether the syndrome or symptoms represent distinct diseases or unique responses but are simply responses of the central nervous system to a variety of stimuli.** The fact that the DSM allows us to group patients with similar symptoms together is also its greatest weakness, in that we may group together entities that have very different etiologies and may require very different treatments. **Using large databases containing symptom profiles of psychotic patients, Kendall cogently demonstrated that it is impossible to separate these patients into two distinct groups with either schizophrenia or affective disorders. He notes that in most cases, the apparent distinction between schizophrenia and affective disorder is based on generalizations about the two extreme ends of a continuum of symptoms, while most of the patients have a mixture of symptoms that make up most of the continuum** (Kendall, 1991). In epidemiological terms, this can be described as a unimodal distribution rather than a bimodal distribution. In other words, there is no "point of rarity" in symptom profiles that clearly separates samples of psychotic patients into two clear and distinct groups.

DSM-IV in Practice

The categorical approach is one of the main limitations of the DSM. It makes us believe that a patient is either in one category or another—they either have schizophrenia or a mood disorder—whereas in reality we may be dealing with illnesses that have *dimensional* characteristics and thus the two groups may be artificial. **A dimensional approach would allow clinicians to treat patients as if they all have the capacity for similar symptoms, although with varying intensities. Instead of considering an "either/or" diagnosis, the clinician looks at the patient's most *prominent* symptoms.** This is particularly true for patients with personality disorders; it would seem that personality characteristics represent more of a dimension than a category. **The major practical criterion for designating a personality disorder is whether the person is**

successful or not. If an obsessive person is successful, then he or she is noted to have obsessive traits; if he or she happens to be unsuccessful, then we label that person as having an obsessive compulsive personality disorder. People with many of the traits necessary to make the diagnosis of anti-social personality disorder are often only labeled as such when they have failed in life. However, none of these factors are limitations in clinical practice, particularly if the DSM-IV is used as it is meant to be used, as a guide to clinical practice. The introduction to DSM-IV clearly states this: "The specific diagnostic criteria included in DSM-IV are meant to serve as guidelines to be informed by clinical judgment and are not meant to be used in a cookbook fashion."

It is the use of DSM as more than a guideline to clinical practice that creates the problems with its application. As a guideline, it is only part of the clinical diagnostic process. However, its very utility and quality has made it easy for clinicians to consider it to be all there is to the diagnostic process. What the DSM-IV diagnosis does is put us in the "ball park" of the patient's major pathology. For example, **if the patient's symptoms fit the criteria for a major depression disorder, this tells us is that the predominant symptoms are those of depression. It does not tell us the etiology of the depressive symptoms, so a differential diagnosis of the potential causes of these symptoms is still necessary. The DSM-IV diagnosis does not indicate the treatment but, rather, offers some guidelines for selecting treatments that have been useful for similar conditions. The DSM-IV diagnosis tells us nothing about the genetics and significant family relations of the patient.** The DSM-IV diagnosis gives us some general information about the outcome of treatment in groups of depressed patients, but this is only a statistical prediction of the individual patient's response to treatment. Finally, **the DSM-IV diagnosis tells us nothing about the patient's story.**

DSM-III through IV have truly been major advances, but they make up only one part of the diagnostic process. The DSM diagnosis provides only part of the information we need. **Perhaps the key to patient care is learning the patient's story, or narrative. Karl Jaspers, a superb observer of clinical phenomenology, emphasized empathy as the key to understanding the patient.**[16] **It is vital that we restore this aspect of patient care to our diagnostic process.** How does the patient's experience resonate with our own? What is it like to be this person? A good clinician moves back and forth between detached observation and empathic probing. Only through such a process can we distinguish between a belief related to being a member of a strange sect and mood-congruent delusion, for example. This is different from empathy in psychotherapy. **This empathic probing is more like making an inquiry into each patient's experiences, and determining how they relate to the reported symptoms.** Empathy is often best gained through the patient's narrative, which illuminates how the patient copes with and adjusts to life. Based on this insight, a hypothesis can be formulated to understand the patient's problems and symptoms; otherwise, they may be considered no more than "biochemical defects." We should merge each patient's story with our own observation of the patient to make a diagnosis. This will require well-cultivated observational skills.

Future Directions

Until the etiologies of each disorder that confronts psychiatrists have been delineated, the approach to diagnosis that was started by DSM-III and further refined by DSM-III-R and DSM-IV is important and a vast improvement over earlier methods. Until we reach that "state of grace," several areas will need to be addressed. **Perhaps most pressing is the need to develop a way to recognize individual patient differences using the DSM-IV system. One proposal is to add another axis, one that specifies the patient's predominant coping mechanisms.** This is under study and has been included in the Appendix to DSM-IV, where it is identified as a *Defensive Functioning Scale*. This study may result in a nomenclature that reflects a more comprehensive patient profile.

Another difficult issue is knowing when to treat *"sub-threshold"* conditions. How do we know when a disorder starts? When does sadness become depression? Will we include laboratory tests—such as neuropsychological tests, EEGs, imaging studies, and neuroendocrine studies—in the diagnostic criteria? **It will also be important to identify specific aspects of personality and psychopathology that can be designated bet-**

ter as *dimensions* rather than *categories*. A dimension is a personality trait from 0%–100%. Some people have a little of a specific trait or a lot. A categorical diagnosis is what the DSM-IV is used for. The patient either meets the diagnostic criteria and falls into the category or not. Perhaps future DSMs will combine dimensional and categorical features. All of this highlights the fact that the use of the DSM without knowing etiology has resulted in an arbitrary classification system.

The arbitrary nature of the system was graphically demonstrated by an anecdote concerning Robert Ressler, the former head of the FBI's Behavioral Science Unit and the person who coined the term "serial killer" that was mentioned during a lecture at an APA meeting. One of the serial killers he examined was a giant—6 feet nine inches tall and weighing more than 300 pounds—with an IQ of over 170. This man had killed nine people, including his parents. He was working in the prison mental health unit, so he was quite familiar with psychiatric terminology. Ressler asked him during an interview where he thought he would fit in the DSM-III. The serial killer thought for a while and then said, "You know, Doc—I don't think I fit in DSM-III. I will probably be in VI or VII."

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Questions Based On This Lesson

To earn CE credits, answer the following questions on your quiz response form.

45. Which of the following was *not* one of the steps involved in creating DSM-IV?

A. Solicitation of expert opinion for each DSM-III-R category

B. A comprehensive literature review of each diagnostic category in relation to the utility of the specific diagnostic criteria

C. Compelling data-based research support for any changes to be introduced

D. Submission of these results to a panel of patients to determine whether or not the conclusions corresponded to their experience of illness

46. Which of the following is/are major limitations of DSM-IV as cited by the author in his statement that the problem lies not so much in the nomenclature as in how DSM-IV is used in practice?

A. The search for symptoms often colors the clinician's perception of a patient's actual functioning.

B. Psychiatrists may be encouraged to believe that after making a diagnosis they really know quite a bit about each patient.

C. Psychiatrists may be led to assume that the diagnosis invariably dictates the type and length of treatment and predicts the outcome.

D. All of the above

47. Relying primarily on DSM-IV may often encourage clinicians to ignore a factor which Karl Jaspers emphasized as being the key to understanding any patient. Which of the following factors does this statement describe?

A. Careful history-taking

B. The elucidation of specific aspects of each patient's psychopathology

C. Empathy

D. Non-intrusive listening

48. According to the author, misuse of the DSM-IV is demonstrated by which of the following diagnostic pitfalls?

A. Clinicians try to force-fit patients into existing diagnostic criteria rather than developing new categories.

B. Clinicians use the "chinese menu" approach, in which any of the symptoms presented can be used to make the diagnosis as long as they add up to the right number of symptoms and no one symptom is the key to diagnosis.

C. Often only a few "target" symptoms are used to determine efficacy of treatment if the diagnosis is not clear.

D. All of the above

You have just completed the program. Please record your answers on the enclosed quiz response form and be sure to save a copy of your answers for your records. Thank you!

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Jealousy, Communication, and Attachment Style

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Many of the conclusions in this report are based on data presented in a study by Guerrero, L. K. (1998) Attachment-style differences in the experience and expression of romantic jealousy. *Personal Relationships, 5,* 273–291.

Introduction

Most people report experiencing jealousy at least once in their romantic relationships, regardless of how satisfied they are in these relationships. Romantic jealousy occurs when people feel threatened by a third party who could either replace them or alter the quality of their relationship. White and Mullen (1989) defined romantic jealousy as **"a complex of thoughts, emotions, and actions that follows loss of or threat to self-esteem and/or the existence or quality of the romantic relationship. The perceived loss or threat is generated by the perception of a real or potential romantic attraction between one's partner and a (perhaps imaginary) rival"** (p. 9). Jealousy can also be distinguished from envy. People feel jealous when someone threatens to take something they value away from them, and envious when they want something valuable that someone else has (Guerrero & Andersen, 1998a; Salovey & Rodin, 1985). In the case of romantic jealousy, people worry that a valued relationship will be taken away from them.

Romantic jealousy is one of the most powerful emotions that humans experience. In the *Bible*, one of the Songs of Solomon (8:6) describes jealousy to be "as cruel as the grave." In *Othello*, Shakespeare refers to jealousy as a green-eyed monster. Psychologists have also likened jealousy to war and natural disasters. For example, Brehm (1992) described jealousy as the "San Andreas fault running beneath the smooth surface of an intimate relationship. Most of the time, its potential lies hidden. But when its rumblings begin, the destruction can be enormous" (p. 155). As

these comparisons to death, monsters, and earthquakes suggest, **jealousy can lead to a host of negative relational outcomes, including suspicion and distrust, feelings of fear and inferiority, relational conflict and dissatisfaction, relationship break-up, and in a small number of cases, violence** (Guerrero & Andersen, 1998a).

However, jealousy also has a bright side. When people feel jealous, they often realize how much they love their partners. As Salovey and Rodin (1985) put it, "jealousy can be a reasonable and healthy emotion. Sometimes the irrational feelings of jealousy can be taken as signs of caring and devotion, rather than as possessiveness and insecurity" (p. 29). **Pines** (1992) **listed several positive consequences of jealousy, including feeling more passionate toward the partner, becoming more committed to the relationship, and appreciating the partner rather than taking her or him for granted.**

Why does jealousy have positive consequences in some relationships and negative consequences in others? One explanation is that jealousy is seen as more rational and justified in some situations than others. Personality factors, such as insecurity and dependency on the relationship, may make some individuals more prone to jealousy than others. If a person always seems to be suspicious and jealous without good cause, the partner is likely to perceive these feelings as irrational and react negatively to them. However, if a person occasionally becomes jealous in the face of an actual threat, the partner is likely to be sympathetic to the jealous person's feelings.

One specific personality factor that is likely to influence jealousy is *attachment style*. An attachment style is a social interaction style that is based on how a person views her/himself and other people (Bartholomew, 1990, 1993). People can view themselves and others positively or negatively. When people see themselves positively, they have high self-esteem and perceive themselves as worthwhile, lovable individuals. In contrast, when people see themselves negatively, they have low self-esteem and perceive themselves as inferior and unlovable. When people see others positively, they generally perceive people to be responsive and caring, and they see relationships as rewarding, enriching experiences. In contrast, when people see other negatively, they generally perceive people as rejecting and unresponsive, and they see relationships as hurtful or unimportant. **Because there is a positive association between low self-esteem and jealousy** (White & Mullen, 1989), **a person's attachment style is likely to impact how jealousy is experienced. Similarly, because people typically only feel jealous when a valued relationship is threatened, individuals who see relationships as rewarding may be more likely to feel jealous than individuals who see relationships as hurtful or unimportant.**

Communication also influences whether jealousy has positive or negative relational consequences. **When jealous individuals display their negative emotion aggressively, threaten to retaliate, or avoid talking about their feelings, they report less relational satisfaction** (Andersen et al., 1995; Timmerman, 1999). **In contrast, when jealous individuals share their feelings within the context of open, nonaggressive discussions about the relationship, they report experiencing higher levels of satisfaction, perhaps because their fears are allayed and/or the "rules" of the relationship have been successfully renegotiated** (Andersen et al., 1995). Jealousy alone is not the culprit. Rather, jealousy may be most destructive when it is accompanied by negative communication.

This report takes a closer look at the above issues by describing how attachment style affects both the experience and communication of jealousy in romantic relationships. Included is a brief overview of the research on emotional and communicative responses to jealousy, followed by a general discussion of attachment styles. The final section of the report links these areas of research by examining attachment-style differences in jealous emotion and communication to apply theory to practice.

Experiencing and Communicating Romantic Jealousy

Jealous Cognition:

The jealousy experience is marked by both cognition and emotion. **When people feel jealous, they often go through a complex cognitive appraisal process that involves three steps** (White & Mullen, 1989). **First, the jealous individual determines whether there is potential for a rival relationship to exist.** If

the potential for a rival relationship exists, **the jealous individual makes a second appraisal to determine if there is an actual, immediate threat.** If there is an actual threat, **a third appraisal is likely; the jealous individual will estimate the extent of threat that a rival poses.** For example, if a rival relationship develops, is it likely to be short-term or long-term? In addition, the jealous person is likely to compare her/himself to the rival to determine who is more attractive, talented, caring, successful, and so forth. To the extent that the jealous person compares negatively to the rival, a larger threat is perceived.

At any point during the appraisal process, two global assessments of cognitive jealousy can be made (Guerrero et al., 1995; Pfieffer & Wong, 1987). First, researchers can assess how much cognitive worry jealous individuals experience. Cognitive worry focuses on the degree to which other people are attracted to the partner. This type of worry is measured by items such as "I worry that others are chasing after my partner" (Pfieffer & Wong, 1987). Second, researchers can assess how much cognitive suspicion is present. Suspicion refers to the degree to which a person believes a rival relationship actually exists, and is measured with items such as "I think my partner is developing an intimate relationship with someone else."

Jealous Emotion:

Jealous individuals can experience a variety of emotions. White and Mullen (1989) proposed six basic composites of jealous emotion:

- *Anger*; which includes hate, disgust, annoyance, and rage
- *Fear*; which includes anxiety and general distress
- *Sadness*; which includes depression and hopelessness
- *Envy*; which includes resentment and begrudging feelings
- *Sexual arousal*; which includes lust, passion, and desire
- *Guilt*; which includes regret and embarrassment

Empirical studies have confirmed that these six emotions are a common part of the jealousy experience, with anger and fear usually emerging as the most central emotions (Guerrero & Yoshimura, 1999; Sharpsteen, 1991; Trost & Yoshimura, 1999). **Some people also report experiencing positive emotions, such as pride and appreciation, when others are attracted to their partner. Because jealous people experience various combinations of emotions, each jealousy experience is unique.**

Jealous Communication:

Jealous individuals have a diverse array of communicative responses at their disposal. Guerrero et al. (1995) uncovered eleven different ways that people communicate (or avoid communicating) jealousy to their romantic partners; these are summarized below.

- *Negative Affect Expression*: nonverbal expressions of jealousy-related affect that the partner can observe, such as crying or acting anxious
- *Integrative Communication*: direct, nonaggressive communication about jealousy with the partner, such as disclosing feelings and trying to renegotiate relational rules
- *Distributive Communication*: direct, aggressive communication about jealousy with the partner, such as making accusations or being sarcastic and rude
- *Active Distancing*: indirect, aggressive means of communicating jealousy to the partner, such as giving the partner the "silent treatment" or withdrawing affection
- *Avoidance/Denial*: indirect, nonaggressive communication that focuses on avoiding the jealousy-invoking issue, such as pretending to be unaffected by the situation

and denying jealous feeling when confronted by the partner

- *Violent Communication*: threatening or actually engaging in physical violence against the partner, such as slapping the partner or pulling the partner away from the rival
- *Surveillance*: behavioral strategies designed to find out about the rival relationship, such as spying on the partner or looking through the partner's belongings for evidence of an affair
- *Compensatory Restoration*: behavior aimed at improving the primary relationship and/or making oneself more desirable, such as sending the partner flowers or gifts and trying to look more physically attractive
- *Manipulation Attempts*: moves to induce negative feelings in the partner, such as flirting with others to make the partner jealous or trying to make the partner feel guilty
- *Rival Contacts*: direct communication with the rival about the jealousy situation, rival relationship, or partner, such as asking the rival to stop seeing the partner or asking the rival how s/he feels about the partner
- *Violent Behavior Toward Objects*: directing violence toward objects, such as slamming doors, throwing the partner's possessions out of the house, or scattering the partner's make-up across the room

In later work, Guerrero and Andersen (1998b) identified three additional communicative responses to jealousy.

- *Signs of Possession* involve publicly displaying the relationship to others so that rivals know the partner is "taken." Examples include introducing the partner as "my girlfriend" or "husband," and kissing the partner in front of potential or actual rivals
- *Derogating Competitors* involves making negative comments about potential rivals to the partner and others, such as "bad-mouthing" the rival in front of the partner or expressing disbelief that anyone would be attracted to the rival.
- *Relationship Threats* involve threats to terminate or deescalate the relationship, or to be unfaithful. For example, the jealous individual could threaten to date other people if the partner continued to see the rival

Attachment Styles

Attachment theory provides a good framework for studying personality differences and their correlation to the experience and expression of jealousy. Attachment theory was originally proposed to study how parent-child interaction affects personality development (Ainsworth et al., 1978; Bowlby, 1969, 1973, 1980). Although Bowlby and Ainsworth acknowledged that attachment processes were prevalent across the lifespan, researchers did not begin studying attachment within adult relationships until the mid-1980s. **Early studies on adult attachment identified three styles equivalent to those found in the child development literature: *secure*, *avoidant*, and *anxious-ambivalent*** (see Hazan & Shaver, 1987). Secures self-define themselves as well-liked and perceive others as generally accepting and well-intentioned. Avoidants define themselves as able to get along well without others, whereas Anxious-Ambivalents define themselves as unable to get along without close relationships.

In the early 1990s, Bartholomew (1990; Bartholomew & Horowitz, 1991) reconceptualized adult attachment styles to include four types: secure, preoccupied, dismissive, and fearful avoidant. Each of these styles is based on how positively or negatively people view themselves and others.

Secures:

***Secures* see themselves and others in a positive light** ("I'm okay, you're okay"). They have high self-esteem and report an absence of serious relational problems (Bartholomew, 1993). They have the capacity for close, fulfilling relationships, but they can get along without relationships if they have to, and they feel comfortable trusting and depending on others. Secures are also flexible in communicative situations and display high levels of social skill (Bartholomew, 1990; Guerrero & Jones, 2000), which reinforces their positive view of self and others. **In short, Secures enjoy their relationships with others, but are also self-sufficient.**

Preoccupieds:

***Preoccupieds* perceive themselves negatively but see others positively** ("You're okay, but I'm not okay"). When they are without a close relationship, preoccupieds feel lost and unable to cope. They are overly dependent and need a close relationship to help them feel good about themselves. As Bartholomew (1990) put it, preoccupieds have an "insatiable desire to gain others' approval and a deep-seated feeling of unworthiness" (p. 163), and they "reach out to others in an attempt to fulfill dependency needs" (p. 165). **Because they rely so much on their relationships, they are often demanding and smother their partners, which can push them away, thereby reinforcing the idea that they are unworthy of love.**

Dismissives:

***Dismissives* perceive themselves positively, but see others negatively** ("I'm okay, but you're not okay"). These individuals might be best characterized as counterdependent—they are so self-sufficient that they shun close involvement with others. Counterdependence may be a defensive strategy that allows people to maintain self-esteem without opening themselves up to the scrutiny and criticisms of others. Rather than becoming involved in relationships, dismissives often focus on work, hobbies, and self-improvement (Bartholomew, 1990). They have trouble trusting and depending on others, and see relationships as nonessential. Dismissives also lack the motivation to build and maintain close relationships, preferring to be by themselves. **In keeping to themselves, they reinforce the idea that they can get along fine without others.**

Fearful Avoidants:

***Fearful Avoidants* see themselves and others negatively** ("I'm not okay; you're not okay"). The key characteristic of fearful avoidants is that they are afraid of hurt and rejection. Often these individuals have been hurt in the past, and they would rather be alone than risk being rejected or having to go through another painful relational experience. As Bartholomew (1990) put it, fearful avoidants "desire social contact and intimacy, but experience pervasive interpersonal distrust and fear of rejection" (p. 164). **Because of their fears, these individuals avoid social situations, show social anxiety, and are hesitant to become emotionally attached to their partners** (Guerrero, 1996). **Paradoxically, being involved in a satisfying, committed relationship would be the best remedy for their problems, but they are afraid to take this step** (Bartholomew, 1990).

Communication, Attachment, and Jealousy: Connecting Theory to Practice

As mentioned previously, research has shown that certain communication strategies are more effective than others when dealing with jealousy (Andersen et al., 1995; Buss, 1988; Timmerman, 1999). **This suggests that practitioners could design programs that help couples use constructive communication to cope with jealousy.** For example, jealous individuals who express negative affect within the context of integrative communication tend to report the most relational satisfaction. These individuals appear sincerely hurt and concerned about their relationships without behaving in an accusatory or retaliatory manner. Some level of compensatory restoration can also be effective, provided that the partner does not see these behaviors as desperate, smothering attempts to win her or him back. On the other hand, jealous individuals who express negative affect with distributive communication, relationship threats, and/or violence tend to be less satisfied. Similarly, those who avoid communicating about jealousy report low levels of satisfaction. **Thus, train-**

ing programs should focus on teaching jealous individuals how to express negative emotion constructively while engaging in integrative communication with the partner and employing a moderate level of compensatory restoration.

Research has also uncovered attachment-style differences in jealousy (Guerrero, 1998; Sharpsteen & Kirkpatrick, 1997). These differences suggest potential interventions that could help individuals cope with their jealousy more effectively. To help illuminate possible interventions, findings related to each of the attachment styles (as reported in Guerrero, 1998) are described next, followed by suggestions for incorporating these findings into practice. A revised version of Guerrero's (1998) attachment measure can be found in the appendix. Notice that this system includes both categorical and continuous measures to help practitioners better assess how much a particular person identifies with each style.

Secures:

In Guerrero's (1998) study, **individuals who categorized themselves as *secure* reported relatively low levels of cognitive suspicion and worry. However, they reported fairly high levels of jealousy-related fear, suggesting that secures typically do not worry about rivals interfering with their relationships, but when they do feel a threat, they are likely to experience some fear, presumably because they care a great deal about their relational partner.** When secures were jealous, they were likely to report expressing their jealousy through integrative communication and compensatory restoration, which typically have positive effects on relationships (Buss, 1988; Guerrero & Andersen, 1998b). People who reported high levels of security and confidence also reported engaging in less negative affect expression and surveillance. Thus, **less intervention is likely to be required for secures than other individuals given that they show a fairly positive profile of jealous communication. Still, training focused on showing these individuals that it is okay to express negative affect within the right context may be helpful.**

Preoccupieds:

Individuals who identified themselves as ***preoccupied*** **reported relatively high levels of cognitive suspicion and worry, as well as high levels of fear and sadness** (Guerrero, 1998). Because preoccupieds have put considerable investment into their relationships and crave excessive intimacy, it makes sense that they would be especially susceptible to jealous thoughts and feelings. Preoccupieds also reported using integrative communication and compensatory restoration to deal with jealousy, presumably because they want to save their relationships. In addition, **preoccupieds reported expressing negative affect and using surveillance behavior more than the other attachment-style groups.** Interestingly, the negative self-image that preoccupieds hold may make them more likely to compare themselves negatively to rivals, thereby leading to envy.

These results are consistent with those from other studies. Hazan and Shaver (1987) found anxious-ambivalents (who are similar to preoccupieds) to be the most jealous of the attachment styles they studied. Similarly, Collins and Read (1990) found that anxiety was associated with obsessive, jealous love, and Radecki-Bush, Farrell, and Bush (1993) found that anxious attachment was associated with self-blame. These findings suggest that the combination of negative perceptions of self and positive perceptions of others that preoccupieds possess leads to increased levels of jealousy.

The picture for preoccupieds, however, is not all bleak. They already tend to use two of the communication strategies that are linked with positive outcomes—integrative communication and compensatory restoration. The key to making them more effective communicators may be training designed to prevent them from using too much compensatory restoration, and to refrain from using surveillance techniques. Exercises that help build self-esteem are also likely to be particularly helpful for preoccupieds who show a tendency to be envious and blame themselves. Finally, if jealousy is unwarranted, it would be helpful for the partners of preoccupieds to learn how to be patient and reassure them of their value.

Dismissives:

Those who identified themselves as ***dismissive*** reported relatively low levels of cognitive suspicion, cognitive worry, fear, and sadness. In addition, they were likely to report using avoidance/denial to cope with jealousy

(Guerrero, 1998). **In other words, dismissives were unlikely to be very jealous, but if they were jealous, they were likely to avoid potentially jealousy-invoking situations and to deny feeling jealous if questioned by their partners.** This makes sense given that dismissives see relationships as nonessential, are unlikely to be highly invested in their relationships, and are usually not as intimately connected to their partners as are people with secure or preoccupied styles. Therefore, a jealousy-inducing event is not as threatening to them.

Data from Guerrero's (1998) study also showed that people who saw relationships as secondary tended to experience low levels of jealousy-related fear and sadness, and not to use negative affect expression. These individuals were also unlikely to express jealousy using integrative communication or compensatory restoration, perhaps because they did not want to invest much effort into maintaining their relationships. Thus, dismissives showed a pattern of little jealousy experience and few jealousy expressions. This pattern has two possible implications. **First, if dismissive individuals are not jealous, even in the face of actual threats to their relationships, their lack of jealousy could be frustrating to relational partners who might seem them as uncaring. Second, if dismissive individuals hide or deny their feelings when they are jealous, this could be destructive to the relationship as their partner will not know of the jealousy and feel that they are uncaring because of the lack of emotion expressed** (Andersen et al., 1995). **Thus, intervention programs might focus on helping dismissives to express jealous feelings when they do occur.**

Fearful Avoidants:

Finally, ***fearful avoidants*** **showed a unique pattern that was similar in some ways to preoccupieds and similar in other ways to dismissives.** People who classified themselves as fearful avoidant reported relatively high levels of cognitive suspicion and cognitive worry, as did preoccupieds. This is probably because fearful avoidants have been rejected in the past and worry that they will be abandoned in the future as well. However, the communication patterns of fearful avoidants mirrored the dismissive pattern, with fearful avoidants reporting high levels of avoidance/denial. Just as they shy away from developing fully-committed relationships, they also shy away from acknowledging and expressing their jealous feelings.

Guerrero's (1998) data showed that people who fear intimacy tended to report high levels of surveillance behavior, as well as low levels of integrative communication. The suspicion that fearful avoidants experience may well lead them to check up on their partners or look at their phone bills to see who their partners have been calling. The tendency against using integrative communication may stem from their fear of social interaction—individuals who fear intimacy may worry that an open discussion about jealousy-related issues may lead to rejection, more hurt feelings, and possibly even relationship termination. Thus, as for dismissive individuals, **intervention programs for fearful avoidants might focus on training designed to help jealous individuals open up and discuss their feelings in a constructive, integrative manner. As with preoccupied individuals, intervention programs that focus on bolstering self-esteem may also be particularly helpful.**

Conclusion

Jealousy is a part of the fabric of many relationships. This does not mean, however, that jealousy has to be destructive. Research suggests that some people are more prone to jealousy than others. When jealousy is justified, the partner is more likely to be sympathetic than when jealousy stems from an irrational fear. Research also suggests that certain forms of communication are more effective than others in helping couples cope with jealousy. Specifically, couples who express jealousy while using high levels of integrative communication and moderate levels of compensatory restoration are more likely to be satisfied than those who express jealousy using distributive communication, relationship threats, and/or violence, or those who deny jealous feelings altogether. Although many factors undoubtedly play a role in determining how people experience and express jealousy, attachment style appears to play a particularly important role. **Thus, practitioners would be wise to keep in mind that interventions that work for a jealous individual with one attachment style may not work as well for someone with another attachment style.**

Appendix

ATTACHMENT STYLE MEASURE

This questionnaire asks you to think about your general attitudes toward yourself, others, and relationships. There are no right or wrong answers. Please use the following codes to indicate the extent to which you agree or disagree that each of the following statements characterizes you:

1 = disagree strongly, 2= disagree, 3= disagree somewhat, 4= neither agree nor disagree, 5= agree somewhat, 6= agree, 7= agree strongly

		DS						AS
1.	I sometimes worry that I do not really fit in with other people.	1	2	3	4	5	6	7
2.	I am extremely self-sufficent and get along well on my own.	1	2	3	4	5	6	7
3.	I would like to depend on others,but it makes me nervous to do so.	1	2	3	4	5	6	7
4.	I rarely worry about what other people think of me.	1	2	3	4	5	6	7
5.	I would like to trust others,but I have a hard time doing so.	1	2	3	4	5	6	7
6.	I worry that other people do not like me as much as I like them.	1	2	3	4	5	6	7
7.	I worry a lot about the well-being of my relationships.	1	2	3	4	5	6	7
8.	I prefer to keep to myself.	1	2	3	4	5	6	7
9.	I worry about getting hurt if I allow myself to get too close to someone.	1	2	3	4	5	6	7
10.	It is extremely important to me that others like me.	1	2	3	4	5	6	7
11.	I would like to have closer relationships,but I worry that close relationships will end up being painful.	1	2	3	4	5	6	7
12.	It is important to me to avoid doing things that others may dislike.	1	2	3	4	5	6	7
13.	If other people will disapprove of something,I avoid doing it.	1	2	3	4	5	6	7
14.	I tend not to take risks in relationships for fear of getting hurt or rejected.	1	2	3	4	5	6	7
15.	I sometimes worry that I don't "measure up" to other people.	1	2	3	4	5	6	7
16.	I am an extremely independent person.	1	2	3	4	5	6	7
17.	I am confident that other people will like me.	1	2	3	4	5	6	7
18.	I worry that others do not care about me as much as I care about them.	1	2	3	4	5	6	7
19.	I put much more time and energy into my relationships than I put into other activities.	1	2	3	4	5	6	7
20.	I wonder how I would cope without someone to love me.	1	2	3	4	5	6	7
21.	I worry that others might reject me.	1	2	3	4	5	6	7

Appendix

ATTACHMENT STYLE MEASURE (CONTINUED)

1 = disagree strongly, 2= disagree, 3= disagree somewhat, 4= neither agree nor disagree, 5= agree somewhat, 6= agree, 7= agree strongly.

		DS						AS
22.	I rely on myself much more than I rely on others.	1	2	3	4	5	6	7
23.	I am confident that others will accept me.	1	2	3	4	5	6	7
24.	I find it relatively easy to get close to people.	1	2	3	4	5	6	7
25.	I do not like to depend on other people.	1	2	3	4	5	6	7
26.	Maintaining good relationships is my highest priority.	1	2	3	4	5	6	7
27.	Intimate relationships are the most central part of my life	1	2	3	4	5	6	7
28.	I sometimes worry that my relational partners will leave me	1	2	3	4	5	6	7
29.	I am confident that other people will respect me	1	2	3	4	5	6	7
30.	I can get along fine without close relationships	1	2	3	4	5	6	7
31.	I hesitate to develop close relationships because it is easy to get hurt.	1	2	3	4	5	6	7
32.	I like to solve problems by myself.	1	2	3	4	5	6	7

Next,using the rating scale below descriptions 1 – 4, mark how well each of the descriptions fits you by circling a number from 1 to 7 (please do not circle the words).

Description #1: I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient and I prefer not to depend on others or have others depend on me.

very unlike me 1 2 3 4 5 6 7 very like me

Description #2: I am somewhat uncomfortable getting close to others. I want emotionally close relationships,but I find it difficult to trust others completely,or to depend on them. I sometimes worry that I will be hurt if I allow myself to become too close to others.

very unlike me 1 2 3 4 5 6 7 very like me

Description #3: It is relatively easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don't worry about being alone or having others not accept me.

very unlike me 1 2 3 4 5 6 7 very like me

Description #4: I want to be completely emotionally intimate with others,but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships,but I sometimes worry that others don't value me as much as I value them.

very unlike me 1 2 3 4 5 6 7 very like me

Which of the following descriptions from above best describes you? *(Place a checkmark next to only one description.)*

_____ **Description #1** _____ **Description #3**
_____ **Description #2** _____ **Description #4**

Appendix

SCORING KEY FOR THE CONTINUOUS ATTACHMENT MEASURES

Calculate an average score based on the following groupings.The closer a score is to 7.00, the stronger an individual identifies with that particular attachment style. A score close to 1.00 suggests that an individual does not possess any qualities related to a particular style.

Security/Confidence= Questions 15*,17,21*,23,24, and 29.

Fear of Intimacy (Fearful Avoidance)= Questions 3,5,9,11,14,and 31.

Relational Worry (Preoccupation)= Questions 1,4*,6,7,10,12,13,18,20,and 28.

Relationships as Secondary (Dismissiveness)= Questions 2,8,16,19*,22,and 25

*these items must be reverse coded (e.g., a response of 1 should be coded as 7)

Note.The categorical measures are from Bartholomew and Horowitz (1991)

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